BEYOND ABORTION:

PERSONAL NARRATIVES OF COPING, SUPPORT AND EXPERIENCES OF ABORTION SERVICES

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ABSTRACT

Mainstream psychological research suggests that few women experience significant negative responses following abortion. It is suggested that negative responses occur as part of complex life choice issues. In addition, previous research findings indicate that younger women report requiring more information and cope less well post-abortion than older women.

The study *Beyond abortion: Personal narratives of coping, support and experiences of abortion services* documents through loosely structured interviews the experiences of thirteen women who have had an abortion at Lyndhurst Hospital, Christchurch. The purpose for documenting the women's accounts of their experience(s) was to explore their feelings regarding the abortion and the abortion services available to them in New Zealand. The narrative content revealed several themes that included: (1) the impact of no or poor support from the birth father during the decision making process affecting the amount of "choice" women perceived they had, (2) the possible effect of lack of accurate information regarding pain during the operation on perceptions of high pain levels, (3) the different preferences for means of pregnancy termination regarding surgical versus RU486, and general versus local anaesthetic, (4) employment of idiosyncratic strategies by the women to resolve the experience of abortion and (5) acknowledgement that the abortion was the right decision. The experiences of the participants in this study suggest that social attitudes towards abortion are still predominantly negative, and are particularly affected by religious beliefs.

An analysis of narrative articulation, consistent with feminist post-structuralism, revealed the continuing effect of patriarchal discourses on women's perceptions of personal responsibility regarding contraceptive failure, choosing not to reproduce and perceptions of bodily self-determination

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My parents, friends and teachers can be attributed with a significant amount of this achievement. My parents always wanted me to be happy and fulfilled in what I achieved in life. I think I have succeeded thus far. The ones who have made my life both bearable in low times and enjoyable during lifes' highs are my friends and I thank them for their love, encouragement, enthusiasm and continued support.

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To my family; Dennis who has given me practical assistance and encouragement while I have been completing this project: Thank you for your dedication. Reuben: Thank you for loving me through the absences.

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Dedicated to the women who suffered a loss, whether it be an absence of liberty or a loss of health or life via an illegal abortion.

A rural woman nearly dies after aborting herself

> My first abortion was one I had to perform on myself fifteen years ago at the age of seventeen. Twenty miles from the nearest town and doctor, sixty miles from the nearest hospital, on a farm, I had to rely on my husband's boss for transport and almost haemorrhaged to death. I had been using a diaphragm as a contraceptive, which had failed. I stuffed my uterus with cotton wool when a month pregnant. Two and a half months later I miscarried getting out of the bath with a one-year-old babe in my arms. Before I could attend to myself I had to dry and dress the baby. After phoning the doctor, I phoned the boss's wife. It took her half an hour to get ready to drive me to the nearest hospital, sixty miles away.
>
> My second abortion was quite different. It was six years ago at Waikato Public Hospital. By this time I had five children from ten years to one year. So I was on the pill and ill and sick because of it. In the end I got pregnant again. My husband deserted me. Because of the shock of their father disappearing overnight, I now had two bed-wetters and a babe of one year to wash for and consequently I spent three-quarters of my day and night washing, folding, washing, etc. To have another baby to wash and get up to in the night would have been worse than death.
>
> Luckily I had a sympathetic doctor who arranged for me to see Mr B, medical superintendent of Tokanui Hospital. I had a nurse next door who advised me on my behaviour. Mr B advised me to my amazement (after years of grovelling and begging for it) to be sterilized. Three days later I was aborted and sterilized. The pain was dreadful and the scar isn't pretty, but the peace of mind was wonderful. For the first time in twenty-eight years I had sexual satisfaction and am now happily married. My first marriage might have succeeded if I could have been sterilized after my second child as I wished.
>
> (Anon, cited in P. Bunkle, 1988, pp. 25-26)

Reproductive freedom allows all women the liberty to make a choice different from each other.

DEFINITION OF TERMS

Definition of key terms: For the purposes of the current study, it is important to clarify the meaning of key terms. "Abortion" refers to the voluntary termination of a pregnancy, not more than twelve weeks gestation, were the termination was not performed for reasons of fetal abnormality. The term "father" in the context of the current research refers to the biological parent of the products of conception.

The terms "unplanned" and "unintended" are interchangeably used in direct reference to the conditions under which conception occurred. For purposes of the current study, planning is seen as involving a conscious decision to conceive or not to conceive. Women planning to conceive are likely then, to take measures to increase the likelihood of pregnancy occurring (for instance, stopping contraceptive use). Likewise, women whose plan it is not to conceive, are likely to engage in behaviours to avoid the occurrence of pregnancy (included in this could be initiation or maintenance of contraception use. "Unexpected" is used in reference to an absence of planning behaviour (either in trying to achieve or avoid pregnancy) where women may feel they have little ability to control their reproductive lives (due to lack of knowledge, resources and other constraints) (Adler, 1992).

Patriarchy is a term that was picked up by radical feminists, in particular, and made central to social analysis (Randall, 1991). Firestone (1970), in her book *The dialect of sex: The case for feminist revolution* suggests that patriarchy can be seen as a system of "social organisation in which men's control of women is based on their power over wives and children within the family.". This conceptualisation of patriarchy is consistent with its usage in the current research.

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CHAPTER ONE

INTRODUCTION

The women's liberation movement in New Zealand in the 1970's fought, in the abortion law-reform campaign, demanding abortion rights for women as part of a much broader agenda for women's freedom (Bunkle, 1988). Legal abortion was seen as a significant and necessary gain in attaining women's freedom to control their own reproductive lives (Gerber Fried, 1993). Abortion in New Zealand was legalized in 1978, and following this the abortion rights movement virtually disappeared. Two decades later the "right to chose" that is found in New Zealand, in some senses bears little relation to that feminist goal that shaped the fight for legalized abortion. Women's access to abortion services are restricted still by reason of geography, poverty, knowledge, or other barriers.

Pregnancy, unexpected or planned along with the prospect of parenthood is something that most individuals are confronted with either personally or indirectly at some point in their lifetime.

It is possible to argue that pregnancy is a life event that can be controlled , but for a minority of women it is not preventable due to lack of knowledge, financial or practical resources (for example, transport to family planning, money for contraceptives), language and age barriers, and there being no assurance of a completely effective contraceptive method[1]. For these reasons and perhaps many more, women frequently report that their pregnancy was unplanned. When faced with a pregnancy a woman has three options; (1) carry the pregnancy to full term and raise the child, (2) continue the pregnancy and relinquish the child for adoption and (3) terminate the pregnancy through criminal or legal abortion. Chapter two presents a description of these choices for women in New Zealand.

The literature review in chapter three focuses on the option of abortion and

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[1]It is accepted that sterilization, abstinence, and non-penetrative intercourse assure conception will not occur.

examines findings concerning the psychological impact of an elective legal abortion on women, as well as discussing issues concerning coping with abortion and possible implications for further understanding the abortion experience and the system it occurs within. The review of the literature highlights a general consensus among authors and researchers of abortion related issues, that there is little emotional effect exhibited by the majority of women following an abortion (Adler et al., 1992; Adler et al., 1990; Lemakau, 1991; Major et al., 1990; Romans-Clarkson, 1989; Sceats, 1985). However, within the literature, there is a small amount of research reporting severe negative psychological responses by few women post-abortion (Davidson & Clare, 1989; Stone Joy, 1985). Opinions about the nature and extent of these reactions vary widely. Although it has been suggested that negative responses occur as part of complex life choice dilemmas, this does not make them any less relevant for those women. It has also been asserted that in large populations, small percentages translate to a substantial number of women in absolute terms (Armsworth, 1991). Furthermore, the literature on abortion suggests that younger women require more information about termination, report being misinformed at the time of the termination, feel forced by circumstances to choose to terminate and to report coping less well than older women (Franz & Reardon, 1992). The problems reported by younger women however, may not be simply a function of the relatively young age at which the women become pregnant. It is possible that their marginal status as women together with their youthfulness may have lead to them being disadvantaged and oppressed. Poorer coping may be the result of prevailing social attitudes towards them.

Chapter four presents radical feminist theory with respect to reproductive choice and control over the body. In line with radical feminist perspective, the theory of reproductive freedom is documented as voicing the need for women to control their own reproductive lives, and citing the necessity of providing more than the opportunity for abortion (as many women may be denied access through geography, financial constraints, knowledge and other reasons). The importance of the abortion experience to be

empowering rather than dis-empowering for women is highlighted. Feminist post-structuralist theory is considered in this chapter as it provides a tool, through discourse analysis, of analysing construction of meaning and examining relationships of power with respect to the issue of reproductive freedom. Feminist research method along with presentation of content and discourse analysis, consistent with feminist post-structuralism used in data interpretation, is documented in chapter five.

Aim of the study: It is not within the scope of the present study to investigate long term coping with abortion. It is however, intended to document and present the responses and experience of a number of women who have had an abortion at Lyndhurst Hospital in Christchurch, New Zealand. The purpose for documenting women's account of abortion experiences was to explore their feelings about the abortion, and the extent to which their experiences and their perceptions are affected by social attitudes and policies, as well as to examine perceptions of service provision.

To achieve depth and meaning in participant responses, the current study is based on loosely structured interviews with thirteen women who chose to terminate an unplanned pregnancy through abortion services in Christchurch, New Zealand. During the course of the interviews several broad areas of interest were focused upon:

- contraceptive use
- decision making process
- social support - partner, family, friends
- relationships with the father
- procedural aspects of having an abortion
- pain during abortion
- experience with professionals at Lyndhurst
- feelings about having had an abortion
- counselling

Undoubtably, as the researcher in the current study, my feminist beliefs have impacted upon and influenced the topic studied, the selection of relevant literature, the nature and focus of interviews, method of analysis utilized and also the interpretation of information obtained. Psychology has been my other principal academic influence, and with in this the discipline of community psychology provides frameworks in the current research for interpretation and analysis. Feminist values can be seen as complimentary to the discipline of community psychology.

The current study was conducted from an explicitly feminist standpoint assuming the continued oppression of women by patriarchal discourses at both interpersonal and societal levels. Oppression of women via male defined normality and reality within research has been well documented (Anderson & Jack, 1991; Bunkle, 1986; Klein, 1983; Oakley, 1986; Waring, 1988) and is evidenced in the current social and political climate (Bryson, 1992; Bunkle, 1988; International Year of the Family Committee, 1995; Randall, 1991). The assumption of the current research is that recording the experiences of a small number of women who chose to have an abortion will highlight the manner in which this particular group of women experience subjectivity and being marginalized and oppressed both individually and collectively through current social policy.

The scope, generalizability and context of the current research is limited, yet it is believed that the information accessed may add to existing knowledge about women's experience(s) of abortion, and contribute to a growing body of experiential research in this area. Qualitative data obtained in the current study has the potential to provide information to supplement statistical data and inform service providers and policy makers alike of the effects of policy and possible gaps in provision of service.

Additionally, is hoped that providing a vehicle for women's voices to be heard in the public sphere may strengthen the cry for social change and the redressing of current social, financial, political, and educational disadvantage that prevents them from exercising the freedom to choose.

CHAPTER TWO

THE CONTEXT OF ABORTION IN NEW ZEALAND

> **Three points are important to note at the outset. First, the study is not about the poor and the destitute, although some of the women are in that category . . . Secondly, the women are not the problem - the problem is what they are having to deal with . . . Thirdly, women are often identified as if they were a single issue, leading to their further marginalization. (Bagnall, 1995, p. 118).**

Natural increase (excess of births over deaths) and net migration are identified as the two main components of population change (New Zealand official yearbook, 1995). The following section examines fertility, which is one aspect of population process growth as well as presenting options for fertility control and maternal care provisions.

Fertility patterns in New Zealand: Fluctuations in fertility levels have been significant in determining both the size and structure of New Zealand population through history. A peak occurred in 1961, when the total fertility rate was in excess of 4.3 births per woman. Features of these post-war years were the universality of marriage and the younger age at which it occurred, plus a shortening of birth intervals (New Zealand Official Yearbook, 1995). From the early 1960's the fertility rate in New Zealand steadily declined. This downward trend occurred simultaneously with the introduction of the contraceptive pill (although it is not possible to establish a cause-and-effect relationship). Total fertility rate dropped to below replacement level in 1978, and by the year 1983 it had levelled to a sub replacement rate of around 1.92 births per woman (New Zealand Official Yearbook, 1995; Population Monitoring Group, 1985).[2] The decline in New Zealand fertility rates is consistent with decreasing fertility rates in other developed countries during the same time frame (Department of Statistics, 1986; Sceats, 1985). The socially motivated trend of the 1980's for women to delay child bearing until their late twenties or early thirties lead to substantial declines in fertility rates for both the 20 to 24 and the 25

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[2]A total fertility rate of around 2.1 - 2.2 children per woman is required to ensure replacement of one generation by another generation of equivalent size (Sceats, 1985).

to 29 age groups, and only a minor resurgence in total fertility rates (New Zealand Official Year Book, 1995).

Additionally, there was a marked decline in teenage fertility from around 70 births per 1000 women in 1971 to 32 per 1000 women in 1988 (Maskill, 1991). Teenage fertility rates in New Zealand are, however, still high relative to other low fertility countries.

Improved access, and increased reliability of contraception has made it more possible for women to control the timing of pregnancies, and the number of children they bear. Subsequently, many women have delayed childbearing until their late twenties or early thirties enabling completion of education and development of careers and autonomy prior to having children (Petchesky, 1986). In many instances the delay has enabled women to gain tertiary qualifications, attain better employment positions and improved financial positions, which has lead to increased participation of women in the labour force. Radical changes to the structure and formation of family, patterns of marriage (including the growth of de facto relationships), increasing divorce rates and general economic conditions also contribute to fertility (New Zealand Official Yearbook, 1995).

Contraceptive use: New Zealand adolescents have been shown to mostly use condoms or the pill as a method of birth control method (Brander, 1991; McEwen et al., 1988). Non use, or irregular use of contraceptives in unplanned pregnancies has been shown to be due to beliefs that 'it wouldn't happen to them' or that, as a woman they would be labelled as 'looking for sex' if they were on the pill or carrying condoms, rather than being due to lack of information (Allen, 1987; Allgeier, 1993; Gray, 1988; Holly, 1989; Lees, 1986; Phoenix, 1991).

Research has illustrated that women feel contraceptive responsibility should be shared equally between partners (McEwen et al., 1988). The reality that women are required to assume sole responsibility has been cited in research that found control of fertility to be a female, not a male issue (Brooks-Gunn & Furstenburg, 1989; Lees, 1986; Ritchie & Ritchie, 1984).

The domestic purposes benefit: The New Zealand government introduced the Domestic Purposes Benefit (D.P.B.) in 1973, as a benefit for solo parents[3] raising children in the absence of financial or domestic assistance from a partner (Kunowski, 1988). The D.P.B. is payable from the birth of a child until such time as that child reaches the age of fifteen or leaves school and becomes financially independent. The nature and purpose of the D.P.B. is to allow parents to be home to care for their children, while the state provides for them. Strict limits are enforced regarding the amount of income recipients can earn from any source or employment[4] and upon co-habitation arrangements (there are restrictions on partner time). When the benefit was established solo parents over the age of sixteen (the legal age for engaging in sexual relations) were able to be recipients of the benefit, but in 1991 the National Government changed the age of eligibility to eighteen. Sixteen and seventeen year olds are no longer able to receive the D.P.B. This legislative change sends a clear message to young women that they are not viewed as being capable of parenting. It also perpetuates dependence[5] by younger women on partners or extended family as a means of survival by reinforcing the caregiver role for women (Angus & Gray, 1995) and reinforces dependant behaviour. The establishment of a domestic-related benefit attempts to ensure women's place in the private sphere. In addition, it can be seen as a move to ensure that if women are not dependant upon one man they are dependant

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[3]While the D.P.B. is available to parents of both sexes, it is significantly more likely to be women who raise children in a solo parent capacity. In over 80 percent of single parent families, the parent providing for the children is the mother in virtually all countries (Bryson, 1993).

[4]It has been indicated that repeated requests for verification of hours women were engaged in employment while receiving a benefit had jeopardised employment positions for some (Bagnall, 1995).

[5]Economic dependence of women on men exists in western societies. This dependence is created from a lower average wage for women and by restricted work opportunities (Bryson, 1993). This imbalance equates to fewer resources at the time of the birth of a child and also opportunities after the birth. While the D.P.B. was set up initially in recognition of women's economic position, it can be seen as maintaining that patriarchally constituted position.

upon a male system which in turn ensures their subjection. This could also be interpreted as a reflection of the creation of a benefit to meet the state responsibilities in assuring rights and opportunities of the child that are reflected in New Zealand law and social policy practice (Robertson, 1995). The D.P.B. appears to directly reflect child-centred rather than women-centred policy.

The similarity between the benefit and the adult minimum wage means that it is more desirable for many women to remain at home than to work for a roughly equivalent amount of money. This effectively removes women from the workforce and the public sphere. The annual benefit amount (ca. 13,000 compared to the average wage of 30,380) has a further affect in making it more financially desirable for a mother to become dependant upon a partner (and remain in relationships that are less than ideal) than the state . There is a stigma that is associated with depending on this benefit, that in the context of the current study, may be seen as preventing women from choosing this option.

Adoption: In New Zealand, as in other Western countries, women are keeping children born out of wedlock, rather than marrying or to relinquishing the baby for adoption, in increasing numbers (Else, 1991; Herr, 1989; Rockel & Ryburn, 1988). According to New Zealand law adoption is a single act involving the " . . . substitution of new parents for the existing parents of a child." (Butterworth, 1990, p. 6751). The reality, however, is a continual and lifelong process of adjustment and reconciliation. Witness to this is the fact that following the instatement of the D.P.B. many more young women choose to keep their babies, and fewer babies then, were available for adoption (Else, 1991).

Despite the age of the adoption legislation in New Zealand, and its failure to provide adequate support and protection for women (Iwanek et al., 1995), the handling of adoptions has changed dramatically in the course of the past decade, with the emphasis of 'open' adoptions on empowering the birth mother so that she exerts some control over the adoption process. Although, it is noted that there is no mandate for counselling that would ensure informed choice occurs (Iwanek et al., 1995).

Marriage: Marrying partners tend to be older (which is consistent with the later age for parity), and marriage has become infrequent in teenagers (Department of Statistics, 1986; Shannon, 1986). A decrease in the total number of marriages in New Zealand has been partially offset by the increasing trend for people of all ages to co-habit in "de-facto" relationships, or to parent alone (Benfield & Kjellstrom, 1981; New Zealand Official Yearbook, 1995). The changes identified partially account for the dramatic rise in ex-nuptial births from 9 percent of all registered births in 1963 to 38 percent in 1993 (New Zealand Official Yearbook, 1995). Changing social norms along with easy accessibility of welfare benefits have made a major contribution to this increase.

Social policies in place in New Zealand at the present time disadvantage those at the lower end of the socio-economic scale, particularly welfare beneficiaries. Poverty in New Zealand is increasingly impacting upon women (D'Ercole, 1988; McRobbie, 1991), many of whom are supporting families of dependant children. Remaining at home to be a care-giver is not considered an important or high status job as it carries no visible economic value (Oakley, 1986). Many women may be forced for economic reasons either to remain in unstable or abusive relationships, or into prolonged dependence upon families or the state. The options available for women faced with unplanned pregnancy in New Zealand carry intrinsically related social and personal costs. The only other option for some women is to terminate their pregnancy. The remainder of this chapter focuses on abortion, as one of the various options available to women in New Zealand.

Legal abortion in New Zealand: New Zealand law has permitted legal abortions since 1978 in circumstances specified under section 187a of the Crimes Act 1961 (as amended). Under the act, the pregnancy must not be of more than twenty weeks gestation at the time of termination.

Most abortions in New Zealand are carried out under the premise that "the continuance of pregnancy would result in serious danger (not being danger normally attendant upon childbirth) to the life or to the physical or mental health of the woman or

girl.". Referral procedure for an abortion is specified by the Contraception, Sterilisation and Abortion Act 1977. Two certified consultants are required to agree after assessing the woman, that the provisions of the law are able to be met before an authorising certificate can be issued. An Abortion Supervisory Committee continually monitors the abortion law, licences the institutions that perform abortions, appoints consultants and maintains contact

Table 1.0 Numbers and rates of induced abortion in New Zealand 1976-1993.

Year	Numbers	Crude Rate (Per 1000 of total population)	General Rate (Per 1000 women aged 15-44 yrs)
1976	4682	1.5	7.1
1977	5433	1.7	8.1
1978	2094	0.7	5.3
1979	3653	1.2	5.3
1980	5945	1.9	8.6
1981	6759	2.2	9.5
1982	6903	2.2	9.6
1983	7198	2.2	9.7
1984	7275	2.2	9.6
1985	7130	2.2	9.3
1986	8056	2.5	10.5
1987	8789	2.7	11.3
1988	10044	3.0	12.7
1989	10200	3.1	12.8
1990	11173	3.3	13.9
1991	11594	3.4	14.4
1992	11460	3.3	14.2
1993	11725	3.4	14.4

Source: New Zealand Official Yearbook.

with those facilitating the abortions. Additionally, Counselling advisers inform the committee on counselling services provided for women who terminate a pregnancy and other related or relevant issues.

Prevalence of abortion in New Zealand: Abortion rates have risen over 100% since 1976 in New Zealand. As shown in Table 1.0 the rates dropped from 1.7 to 0.7 in 1978 with the change in legislation[6] and have continued to rise steadily since then. Other low fertility countries able to provide adequate and sufficient data on abortion exhibit patterns of rising incidence of abortion, similar to New Zealand, usually after a change in the law. Some countries are now reporting a decline in the number of abortions performed annually. Subsequently, it has been noted that increases in accessibility and availability of abortion does not necessarily produce a sustained increase in incidence (Sceats, 1985).

The proportion of pregnancies for which abortion is an outcome (as opposes to miscarriage and birth) has increased steadily (Sceats, 1985). New Zealand data to date (Table 1.0) does not mirror international trends, suggesting the impact of variables other than solely legislative factors on abortion occurrence (for instance, access to financial resources such as the D.P.B., social climate and acceptability of solo parenthood and abortion, perceptions of adoption). Increases in numbers of pregnancies terminated due to legalized abortion, can only partially account for the decline in New Zealand fertility rates. While legality has not resulted in reporting of increased abortion rates, it has meant a reduction in backstreet or illegal abortions.

In the United States of America, for example, government statistics indicate that voluntary legal abortion has beneficially effected physical health of women. Since 1968, The United States infant mortality has decreased, abortion associated deaths have become almost negligible, as have hospital admissions for incomplete abortions. Mortality and

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[6]It is probable that social attention focused upon abortion during this time restricted access to abortion services. The confusion over the interpretation of the bill and the subsequent closing of the Auckland Medical Aid Centre for terminations also could have affected the abortions carried out during this period (Society for Research on Women in New Zealand, !980).

complication rates of legal abortions have steadily decreased to rates below those of full term pregnancy and delivery (Phillips & Rakusen, 1989). It must be concluded then, that providing the opportunity for legal abortion is better physically and possibly psychologically for women taking this option.

Social descriptors: Women under twenty five years of age are over represented among abortion patients, contributing roughly half of women presenting to clinics. The proportion of all pregnancies terminated is high for the under twenty five age group in comparison to older age cohorts. For example, in 1982, 23 percent of pregnancies to women under the age of twenty ended in abortion, while 11 percent and 7 percent of pregnancies were terminated for the 20 to 24 year olds and 25 to 29 year olds respectively (Sceats, 1985). Interestingly, from 1985, abortion rates have increased for the over twenty age bracket and declined in the under twenty age group. Younger women in New Zealand face a complex situation, in which they are able to obtain abortion without parental consent yet they do not necessarily have the same access to contraception as older women (Nicol, 1987).

During the period of 1978-9 (Table 1.0) there were substantially fewer younger women seeking abortions in New Zealand. However, it is speculated by Sceats (1985), that terminations may have been sought overseas, because, as can be seen from migration data, young women represented a disproportionate number of women travelling to Australia.

Over half of women who have had an abortion in New Zealand have never been legally married and this percentage is constantly rising (although these data do not consider the increasing number of defacto relationships). Most have never had children and the rate of repeat abortions is also increasing.

Maori, Pacific Island women and women from other ethnic groups are also over-represented among women presenting for abortions. These women tend to be older, have previously had more children and visit a general practitioner for confirmation of

pregnancy later than European women in New Zealand (Sceats, 1985).

In addition, Sceats (1985) found, by surveying abortion patients, that thirty-eight percent of these women had not used any contraception in the month prior to conception, thirty-one percent had made intermittent use of some contraceptive device and thirty percent reported regular use of birth control methods .

Application of technology: The procedural factors of the abortion experience have the potential to impact upon a woman's subsequent coping responses.

It is argued that local anaesthetic is administered to women undergoing an abortion because of the risks associated with general anaesthetic (mortality rates increase, depression rate increase, longer recovery period) and possibly there are financial constraints affecting this decision. While these are valid concerns, they can in fact be construed as supporting a patriarchal system of health care where women have not previously been involved in the evolution of the service nor in procedural decisions. It is possible to state that the imposition of compulsory local anaesthetic for the operation initially could have been based on the notion that the woman needed to be aware of what she was doing (punishment?) and grateful of the service provided (patriarchy?). The medical rationale for the administration for this procedure is logical and convincing: It is less time consuming, more cost effective and less risk to the patient to administer local anaesthetic. What needs to be clarified is why the many of women who have a termination for foetal abnormality or a dilation and curettage following miscarriage do so under general anaesthetic, making these women privileged within the health system. Is this due to greater concern for the health of abortion patients or patriarchal perceptions of the differences between the two groups of women?.

The following chapter deals with aspects of the abortion experience within the scope of the current study.

CHAPTER THREE

REVIEW OF RELEVANT LITERATURE

A comprehensive review of the literature from several disciplines is provided. This highlights a variety of theories and findings concerning the post-abortion psychological adjustment of women who have undergone a first-trimester induced abortion. Research findings do not support the existence of a traumatic post-abortion syndrome but they do highlight factors that are indicative of the type of coping response a woman has. These factors are presented in the following section: (1) How wanted the pregnancy is, and how personally meaningful it is; (2) Attributions about the event, (3) Beliefs of self efficacy with respect to coping; (4) Support from significant others (parents, friends, partners); (5) Confidence in decision, for example the presence or absence of conflicting feelings. Factors that have not previously been examined extensively, but that are addressed in this chapter, include post abortion counselling, life events surrounding the termination and individual differences.

The importance of finding meaning: Finding meaning in negative life events is believed to effect the individual's feeling of control over their life and subsequently coping strategies they employ (Bulman & Wortman, 1977).

Major et al., (1985), against their prediction, found that a more meaningful pregnancy is indicative of poorer coping by the women immediately after an abortion, compared to those who do not consider it to be meaningful. They found no difference between the two groups at the three week follow-up assessment. However what is critical in this study, is that the researchers assess the meaningfulness of the pregnancy rather than the meaningfulness of the abortion, failing to make the important and fundamental distinction between the two separate life events. Women who place more value on their pregnancy would be expected to be more distressed following an abortion, yet it is more difficult to predict how the personal significance of abortion effects depression and coping

responses.

Attributions: Effects of attributions[7] a women makes pre-abortion have been examined with respect to her coping following an abortion. Major et al., (1985) found that women who blame the pregnancy on their character exhibit poorer coping strategies post-abortion than those who do not. The degree to which women blame their own behaviour for the pregnancy was found to have no effect on either immediate or three week-follow-up coping responses and behaviours. The implications that the researchers take from this study are that self-character blame (blaming personal characteristics, e.g. irresponsibility) and not self-behaviour blame (blaming behavioural instances, e.g. sexual activity without contraception) distinguishes depressed from non-depressed women post-abortion. The effects the researchers obtained for self behaviour blame could be due to the nature of the phenomenon being observed. For example, research on accident victims, rape survivors, cancer victims and the like focus on unexpected traumas, events that are beyond the control of the individual, whereas pregnancy, in theory at least is a phenomenon that is partly within the control of the individual, despite the fact that most women faced with an unplanned pregnancy describe it as an accident. This argument is supported by the fact that eighty-five percent of the women in research conducted by Major et al., (1985) engaged in self behaviour blame to some extent. It would seem reasonable to expect that a ceiling effect has occurred for self behaviour blame.

One huge limitation to this work, it can be argued, is the fact that Major et al., (1985) are assessing attributions of the pregnancy and relating these to coping with abortion. It would be more appropriate to assess attributions made about the abortion and relate them to subsequent coping responses. Secondly no real distinction is made between causal attributions and blame attributions. In an additional study, Mueller and Major., (1989) assigned women to one of three counselling groups. One altered attributions for

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[7]Attribution theory is a theory of how people explain their own behaviour or the behaviour of others. It examines how we make judgements by attributing actions to internal or external causes (Myers, 1988).

the unwanted pregnancy, one raised coping expectations and the other was a control group. The effects of the interventions are limited to measures of mood and depression. The attributions group showed a significant reduction in reports of negative mood while the expectation intervention group exhibited a significant reduction in depression and a tendency to reduce anticipation of negative consequences.

There was no intervention effect at the three week check-up assessment, but this may be due to the relatively short (seven minutes) intervention counselling session. The researchers conclude that while attributions can effect the individual's state of mind about an event, it is self efficacy that effects and moderates the current mood and negative expectations. Again, the effects of attributions are demonstrated by taking attributions for the pregnancy and relating them to coping with the abortion. It can be argued, that this influence on post-abortion outcomes is not as relevant as attributions made about the abortion with respect to coping post-abortion.

Self efficacy: Bandura (1977) asserts that having a belief in one's self and one's potential enhances both coping and self improvement. Self efficacy, as Bandura has defined it , is acquired by engaging in challenging yet realistic tasks and achieving success, rather than through positive self reasoning (Myers, 1988). Perceived self efficacy is a useful term, but it has to be used with caution, as it does not account for situational factors. Self efficacy is thought to effect the initiation and persistence of coping strategies, so that it affects the extent to which individuals try and how long their effort continues in the face of aversive experiences (Major et al., 1990).

Major et al., (1985), for example, found that of 247 women who underwent first trimester abortion those with high self efficacy beliefs not only coped significantly better on all measures immediately following the abortion, but that the effects were evident three weeks later. They concluded that expectations about coping are strongly related to actual coping behaviours after the operation and that they could be more important than attributions in predicting individual coping.

There are methodological limitations to the study and several problems can be derived from these conclusions. (1) Because the data is correlational it does not indicate the direction of the causal relationship between expectations about coping and actual coping behaviours. (2) The possibility of a mediating variable effecting the relationship has not been eliminated. (3) The findings are based on expectations of coping with abortion and attributions about the pregnancy. This comparison does not seem particularly useful in predicting coping following an abortion. Additionally, it could be useful to examine attributions about the pregnancy and abortion. (4) The assessment of coping immediately and three weeks after the operation is not sufficient to make long term assumptions and predictions.

Mueller and Major., (1989), for example, found that when they randomly assigned 283 women to one of three counselling intervention groups, those with higher self efficacy experienced better moods, were significantly less depressed, and anticipated fewer negative consequences irrespective of the intervention they were subjected to. The researchers concluded that these findings demonstrate the effect of positive self regard in the initiation and persistence of coping behaviour. Again the assumptions are made from measures taken only three weeks after the operation, and do not relate self efficacy to the broader pattern of social support, leaving their assertions unsubstantiated.

Social support and self efficacy: Lazarus et al., (1985) suggest that perceived social support could "buffer" an individual's stress response in the face of negative life events. Following from this they assert that self efficacy beliefs concerning a particular negative life event (such as abortion) can be seen as a stress appraisal measure that is influenced directly by the amount of coping resources available to the individual, including perceived social support.

Alternatively, Bandura (1977) identified four sources of self efficacy beliefs: (1) vicarious learning; (2) verbal persuasion; (3) performance attainments; (4) physiological responding. The theory underlining this model is that through each of these channels

others influence beliefs of self efficacy with supportive exchanges. (Bandura, 1977; Thoits, 1986)

Perceived social support: Perceived social support has been linked to individual well-being and research has indicated that it may indirectly reduce the aversive psychological effects of negative life events.

Bracken et al., (1978) found in a sample of women with unexpected pregnancies that "those choosing to deliver received significantly more support from parents and partners than those choosing to abort.". This study illustrates the potential effects of significant others on the decision to terminate or carry on with the pregnancy and the women's subsequent psychological adjustment. There is strong evidence supporting the relationship between perceived social support and subsequent adjustment to negative life events, however the processes that mediate these effects are not clear.

Significantly, Major et al., (1985) found that the effect of partner presence or absence at the hospital on subsequent coping responses of women undergoing first trimester induced abortions was in the opposite direction to what was predicted. Women accompanied by partners were more depressed and had more physical complaints than those whose partners were not present.

The women whose partners accompanied them were younger and expected to cope less well than those whose partners were not with them. Major et al., (1985) suggest that women who are more depressed before an abortion are more likely to ask partners to accompany them than less depressed women. It could be argued that self monitoring behaviours and experimenter demands could account for the effect of partner presence in this study. For example, a woman by herself is unlikely to say "I wish my partner was here" and more likely to say " I expect to cope quite well on my own". It is possible that the initial non-coping response of the women accompanied by partners may simply be an attempt to elicit more support and acknowledgment from their partner. Further more, it is possible that women not accompanied by partners were in more casual relationships,

making their decision somewhat less conflicted.

Because people make use of many different types of social support (Thoits, 1985), it is important that the assessment measures adequately tap into these areas in order to study the decision making processes of women faced with unwanted pregnancies.

Dakof and Taylor (1990) found that there are individual differences in what people consider helpful in the same circumstances and that different expectations exist about social support from different groups. For example, emotional support is more valued from intimates, except when it is misguided. The doctor's role is perceived as being more informational. Desired support from nurses interestingly parallels expectations about intimates but to a lesser extent. Dakof and Taylor's (1990) study illustrates the importance of separating various forms of social support in future research and also highlights some practical implications concerning social support. This is particularly so in light of Sceats (1985) finding that ten percent of women felt they had not had enough help in making the decision to abort. These women indicated that they wanted to know more about the alternatives to abortion (for example, help available to solo mothers, costs of raising children emotionally and financially) and more about the procedure (for example, instruments used, how they may feel about it afterwards). These findings bring to awareness the potential for inadequacies in professional support provided to help women make decisions about their pregnancy.

Effects of disclosure on social support perceptions: Janet Sceats (1985) found that fifty-eight percent of the women had partner involvement in their decision to terminate their pregnancy (for three percent it was the partner's decision). Therefore forty-two percent made the decision without the participation of their partner. Of the remaining forty-two percent who decided (unaided) to terminate the pregnancy, five percent had disclosed to their partner and he had not shared his opinion and feelings about it, sixteen percent of the women indicated their partner left the decision up to them and the remaining twenty-two percent did not disclose the pregnancy to the father of the child.

I would argue that these women were indirectly effected by their partner who, in his non-supportive role, played an important part in the decision making process of the women (especially in light of the finding of Braken et al., (1978)).

Major et al., (1990) compared women who: (a) did not disclose the pregnancy to significant others; (b) those who disclosed and perceived others to be less than completely supportive, and; (c) those who disclosed and perceived complete support from significant others. They found that women who disclosed and perceived others to be less than completely supportive coped significantly less well than either of the other two groups. The concept of non-disclosure is problematic as it is not clear in the Major et al., (1990) study whether this was due to perceptions that poor support would be given or other reasons.

Major et al., (1990) conclude that there is no direct link between perceived social support and psychological adjustment following the operation, and that the link is accounted for by self efficacy. Therefore they conclude that increased social support is related to increased feelings of competence for coping with abortion and that self efficacy is related to more adaptive coping strategies through social support. The study by Major et al., (1990) presents some important and convincing findings concerning the effects of various degrees of social support, but there are several important limitations. For example: (1) the three hour adjustment measure is insufficient to make long term predictions; (2) the group of women who may have been coerced in to the abortion decision are not accounted for; (3) the nature of the relationship with the father is not considered, and the fifteen percent of the subjects who did not tell their partners about the pregnancy could be in casual relationships; (4) furthermore, the measures of social support are ambiguous and need further validation; (5) therefore, the model they propose does not consider the role of attributions which have been shown to influence perceptions in other areas.

Post-abortion support: While a substantial body of research examines the effect

of social support prior to and during the abortion process, there are comparatively few studies examining ongoing social support following a termination either that provided by significant others or community based support groups.

Partner support before, during and after a termination, has been related to a reduction in the likelihood of the women experiencing feelings of loneliness. Parental support has been shown to be less effective, as was support from other relatives and friends (Robbins & DeLamater, 1985). The generalizability of this research is limited by the fact that the post-abortion measures were taken one week after the operation.

Lodl et al., (1985) set up post-abortion support groups on the premise that women who may be feeling isolated and alone whilst resolving post abortion conflicts or difficulties would appreciate the opportunity for support group involvement. They found that participants in the support groups seemed to show relief when sharing stories and disclosing feelings. This is consistent with Robbins and DeLamater's (1985) finding that twenty five percent of the women in their study experienced feelings of isolation, loneliness and estrangement at least half of the time one week after the operation. Interestingly a large number of women expressed frustration with partners for lack of empathy and support, while it must be noted that some women found it strengthened their relationship (Lodl et al., 1985). The perception of the partner's behaviour appears to be intrinsically linked to the women's responses from the actual decision to abort to her feelings about her decision months or years later.

While there are many post abortion support groups in the community in the United States of America, there are few in New Zealand and Australia. Petersen, (1985, p. 95) in a study of abortion counselling in Australia, found little or no emphasis on post abortion support to the extent that one experienced abortion counsellor proclaimed "that she did not consider an abortion clinic was the right place to do post abortion counselling, and furthermore that she did not see the need for such counselling".

The statement that abortion counselling should not be undertaken at an abortion

clinic warrants further discussion that does not necessarily preclude the potential need for such a service.

It has been suggested that negative feelings may co-exist with positive feelings, so that a woman may feel pleased that she had the right to terminate an unwanted pregnancy and subsequently feel reluctant to reveal negative experiences associated with her abortion due to her fear of lending support to the anti-abortion lobby (Lodl et al., 1985). Lodl et al., (1985) suggest that public education concerning the value of post-abortion support groups may help to overcome the barriers women perceive that exist between themselves and gaining support and acknowledgment of their feelings.

Alternative perspectives on social research findings: Often the anti-choice lobby will claim that termination of a pregnancy is detrimental to the psychological well being of a woman, yet the overwhelming consensus in abortion literature is that for most women, induced abortion does not cause immediate or long term adverse psychological problems (Adler et al., 1990; Adler et al., 1992; Lemkau, 1991; Major et al., 1990; Romans-Clarkson, 1989; Sceats, 1985). Furthermore, much of the literature on post abortion adjustment states that favourable adjustment along with relief is the most common response in the women surveyed (Lemkau, 1988; Lemkau, 1991).

While it is important to consider the wider picture it is necessary not to lose sight of the details. The profound agreement in the literature about most women and generalisations such as "Reactions . . . were quite mild . . . " and "women felt relieved and satisfied" (Romans-Clarkson, 1989, pp. 559-560) both undermine and fail to acknowledge the experiences of women who find the abortion experience to be different. In a study by the Society for Research on Women in New Zealand (1980) only sixty-six percent of the women felt relieved and happy, while the remaining thirty-three did not. Secondly, as Armsworth (1991) indicates, when an event affects large numbers of individuals, very small percentages translate to quite substantial figures in absolute terms, and there is a substantial body of research citing case studies that have established this point (Davidson

& Clare, 1989; Stone Joy, 1985).

It would seem then that while abortion is an ambiguous experience for a small group of women immediately after the abortion, still more experience problems later in life. While women will seldom present to a clinician with abortion-related issues as the primary source of distress, they typically raise these issues as part of complex relationship and life choice issues that they are having problems resolving (Lemkau, 1988). Because some women are not satisfied with their abortion experience it is necessary to further examine potential moderators of their perceptions of abortion as a life event.

The specificity of women's locations: A number of research studies suggest that younger unmarried women without children face greater difficulty in resolving their feelings after abortion (Sceats, 1985; Campbell et al., 1988; Franz & Reardon, 1992). There appears to be a differential impact of abortion on adolescents and adults, with adolescents being more likely to be dissatisfied with the choice of abortion and to feel forced by circumstances to terminate, be unhappy with the services provided and report being misinformed at the time of the abortion, terminate later in the pregnancy and report more severe psychological distress (Franz and Reardon, 1992). Sceats (1985) found that of those who indicated that they were not happy with the abortion and related issues, most were younger, and that younger women also exhibited a tendency to present later, indicating a more conflicted experience. These women indicated they would have liked to know more about options available, costs of raising a child among other things, suggesting that they fall into a different needs category from the older women and that maybe their needs are not being met. The differential affect of age on coping could be due to experience, coping resources, social support, the nature of the counselling and the system they passed through, among other things.

It is important to consider that the effect of age, noted within the literature on abortion outcomes, could be a function of the life or developmental stage that the women are at rather than solely a reflection of chronological age. For example, differences in

career or educational stages, financial security, relationship security, number of friends with children, and willingness to sacrifice current life style are things that are partially related to chronological years but are also related to developmental stages.

With the broad acceptance of research indicating that generally women's responses to abortion are positive, greater attention can be given to understanding the importance of abortion as a developmental event in the life of women and the differential impact or importance of the event rather than debating whether it is inherently traumatic (Lodl et al., 1985).

A different perspective on research premises: Armsworth (1991) acknowledges that society continues to view abortion as a deviant act and that health professionals expect a traumatic response from women choosing to abort. The fact that there is not a widespread reporting of women experiencing negative responses in the literature could be a function of many factors. Armsworth (1991) cites several possible reasons for this anomaly:

(1) Expectations of researchers may have changed with the change of legislation regarding abortion.
(2) Better research design could have eliminated methodological problems that previously existed.
(3) Emotional responses of women today could be a result of greater acceptance of abortion.
(4) The Pro-Life/Pro-Choice debate may have influenced thinking to the extent that it prohibits objectivity.

Point four is especially salient as there is a definite feeling of trying to "prove" or "justify" one perspective in past research. In addition, there is a predominant measuring of clinically significant negative reactions rather than those that are causing more minor effects. Although personally significant disruptions in functioning (for example, relationship strain, emotional distress following abortion) at a non-clinically significant level are seldom considered.

A further limitation of the rationale for much of the literature in the area of abortion

is that research findings derived from studies on negative life events have been used to hypothesise about the roles of different coping responses of women who have undergone a first trimester induced abortion, and this has subsequently directed the course of the research. While research on negative life events provides valuable guide-lines for work on predicting coping with abortion, there are fundamental differences between the negative life events of cancer, arthritis, accidents, rape, for instance, and abortion. This in turn posits limitations to the use of this literature:

(1) Abortion involves two separate negative life events: confirmation of pregnancy and the induced termination of pregnancy.

(2) Pregnancy is in theory a controllable life event (cf. cancer, accident).

(3) The act and experience of abortion is the women's decision (cf, rape, accident).

Lemkau (1988), for example, suggests that the dilemma of the scientist-practitioner model is one of translating research findings so that they are utilisable in idiographic clinical settings. This would be a very difficult task without a general framework of coping and the issues defining and impacting upon it as a point of reference. For this reason further research on the factors that moderate a women's coping responses to the abortion experience based on the following premises is needed, and :

(1) Abortion must be acknowledged as a life event that is inherently different to other traumatic life events.

(2) Research must take an exploratory stance, recording women's experiences rather than trying to politically justify the process of abortion.

Most studies measure coping with abortion in the short or medium term and there is a possibility that the responses they are getting are a function of the coping stage that a woman is at. It would appear that there is the potential for a unique response pattern that women pass through when faced with an unplanned pregnancy, for example: (a) the highest levels of anxiety are likely to be experienced prior to the operation; (b) there is potentially a period of relief both physically and psychologically; (c) there may be a period

of grief, then coping and acceptance. The question that needs to be addressed is whether there is a distinctive coping response and if so what are the behavioural and effective manifestations of the stages of coping.

Based on the summary of abortion literature, there are several tendencies or expected outcomes that are likely to emerge in the current study with regards to post-abortion adjustment. These tendencies are the following:

- That following a termination of pregnancy some women experience negative disruptions in daily functioning that are not severe or of clinical significance but have an impact on their lives and functioning, a minority number of women experience severe adverse psychological responses, and a majority find it to be a positive experience.
- That younger women are less satisfied with their abortion experience and have different needs/expectations than older women.
- That there is a broad pattern of coping behaviour that women engage in following a termination of pregnancy, that is different to coping behaviour in response to other negative life events.

CHAPTER FOUR

FEMINIST THEORY

"Abortion is the fulcrum of a much broader ideological struggle in which the very meanings of the family, the state, motherhood and young women's sexuality are contested" (Petchesky, 1986).

Radical feminism: Radical feminist theory assumes the stance that the oppression of women is of paramount concern as it is **the** fundamental form of oppression (Rowland & Klein, 1990). Men in turn are viewed as oppressing women via patriarchal discourses, that through institutions and ideologies ensure maintenance, perpetuation and recreation of male dominance and female subordination (Rowland and Klein, 1990). Following from this it is recognised and accepted that differences exist between women, yet also acknowledging the universality of women's oppression (crossing race and class boundaries) (Rowland & Klein, 1990). Being woman unifies and incorporates these and other issues that are intrinsically linked to power relations.

Women's experiences of individual problems can be seen as caused by existing in a society that devalues them, limits their access to and knowledge of resources and discriminates against them economically, medically, legally and socially. Institutionalised (familial, educational, religious, sporting, recreational, legal, employment, health care) patriarchy is seen as a major contributor to problems experienced by women in western society.[8]

In emphasising women's resistance to patriarchy both in historical and present contexts (Rowland & Klein, 1990), the initial focus on male power leads to stressing the necessity of women's control of the body for liberation.[9] Within the private sphere, through

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[8]Women and men are generally socialised according to different value systems. Women are socialised in accordance with one value system (female stereotyped) while living largely in an environment based on male-stereotyped values. This duality may result in a value conflict for women.

[9]The rudimentary focus on the women's health movement lead to the examination of issues such as violence against women, abortion, contraception, childbirth, and mothering as well as providing an analysis of sexuality and sex education and the imposition of

patriarchal discourses of the family and marriage, a system exists that ensures women's reproductive capacity leaves her vulnerable through powerlessness, domestic exploitation and economic dependance (Rowland & Klein, 1990). Women's sexuality, then, is critical to their subordination and exploitation (Jagger, 1994). Sexual behaviour, is both a personal and physical act, occurs within a social context and has political outcomes (Millet, 1972). Through the political (challenging the interests of the dominant male social group) act of abortion a women's sense of stability and personal integration can be disrupted.

Patriarchy has a material foundation that ensures its maintenance by structuring economic systems in such a way that women have difficulty in attaining paid labour in a social climate which values only paid labour. As money is the "currency of power", women must have economic independence to provide for themselves without a "breadwinner" (Rowland & Klein, 1990).

As men hold the power to control the laws of reproduction (parliaments and pharmaceutical companies determine access to safe abortion and contraceptives available) it is women's bodies that becomes the "currency of patriarchy" (Rowland & Klein, 1990).

With the development of frameworks for interpretation, radical feminist theorists recognise the centrality of sexuality in the constitution of women's subjectivity. It has also allowed a recognition of the prevalence and extent to which women's bodies are exploited. Subsequently, there has been emphasis placed on redressing control of the body as an essential component of liberation. There are three main facets in the issue of redress: (1) the women's health movement; (2) analysis of the body as a primary site of women's oppression; (3) and the discourse of sexuality (Rowland & Klein, 1990). Adrienne Rich (1976, p. 13), for example, poignantly observed that the contradiction is evident in the institutionalisation of motherhood because "it has alienated women from our bodies by incarcerating us in them".

The right to reproductive freedom: Feminist theory of reproductive freedom

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compulsory heterosexuality.

asserts that abortion has become a symbol of sexual freedom for women and liberation from the confines of a male dominated domestic situation. With autonomy over the abortion decision women (individually and collectively) have the ability to control fertility 100% (Petchesky, 1986).

Two fundamental ideas underlie feminist theory of reproductive freedom:

(1) "Natural rights"

(2) "Socially determined needs".

The first idea originates in the biological connection between women's bodies, sexuality and reproduction and extends the concept of "bodily self determination" to the point of saying that women need to be able to control their bodies and reproductive capacities. The second concept is derived from a historical and moral stance on the social position of women and the needs that this position creates; This concept is extended to the assertion that as women bear the child, and most often are the primary carer for that child in the present social climate, it is women who must decide about contraception, child bearing and abortion (Petchesky, 1986).[10]

A further extension of this theory related to abortion, is that it is not enough to merely provide the opportunity for abortion as many women may still be denied access to it through financial constraints, lack of knowledge or opportunity and also because ultimately it is a medical person who makes the decision not the woman[11].

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[10]To have the right to control one's own body is a fundamental liberal thought, yet reproduction is inherently a social act involving others, and it is an act that ensures the maintenance of society. Difficulties in claiming individual rights for bodily self-determination arise in the contradiction over the status of women as individuals within patriarchal discourse, and this inherently social nature of reproductive activity (Himmelweit, 1988). Abortion, like reproduction, is a social act. Until a safe, effective, self-administered aborting procedure is developed, there will always be negotiation between the women and the supplier of the service.

[11]In the United States of America, doctors have been cited as controlling women's abortion access, as Berer (1988) states " A doctor who may refuse one woman abortion because in his view she ought to be having children, may extract an agreement to be sterilized from another woman because he thinks she is unfit to be a mother.". This situation is probably more extreme than circumstances in New Zealand, but control still lies with medical practitioners who must give certification.

The experience of abortion also needs to be empowering for the women who experience it as it has the potential to further oppress those who have a termination since experiencing coercion, lack of knowledge of procedures, uninformed decision making can all contribute to removing power from women in this situation.

It is argued therefore that the right to legal abortion is a vital and integral part of reproductive freedom[12], but informed and free reproductive decision making depends totally upon affirmative access to resources that allow women to control their lives (Davis, 1988).[13] Only on the fulfilment of these requirements can each woman's reproductive decision be respected (this means the right to choose to have or not to have children, as both decisions can be affected by un-autonomous decisions) (Fried & Ross, 1992).[14]

As few women make reproductive choices in situations where their physical, emotional and material circumstances are ideal, the issue for the current research, then, becomes a question of how the women perceived the choices available to them and the effect of situational factors (for instance perceived partner support, policies regarding state support, financial circumstances, social attitudes) on the choice the women make.

Post-structuralism and discourse analysis: Post-structuralist feminism addresses

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[12]The movement requires a concern with broad aspects of reproductive health and freedom, rather than a concern focused narrowly on abortion (Fried and Ross, 1992). The linking of the pro-choice and reproductive rights movement broadens political applicability and is based on the assumption that sexism, racism, classism and hetero sexism are inseparable challenges to reproductive freedom (Fried and Ross, 1992). Of reproductive freedom, it can be argued that single issue campaigns are less effective politically, but of greater concern is the isolation of one aspect of women's experience from the broader context it occurs within.

[13]The reality that women have predominantly borne in silence their experience of abortion and reproductive health reflects the power and pervasiveness of patriarchal discourse. The exact nature and effect of silencing women's experience differ in accordance with social context, yet invariably the potential to lead to isolation, to denial for support for choices, or for decisions women feel they must make, exists (Gerber Fried, 1993).

[14]The notion of choice in normal speech does not encompass all variants and situations where choices are made. Choices are made within economic, cultural and political contexts where the range of alternatives and decisions made by others may affect what can actually, in practice be chosen (Himmelweit, 1988).

patriarchal institutions identified as preventing freedom to chose with more depth through the analysis of language. Weedon (1987, pp. 40-41), for example, asserts feminist post-structuralism is "a mode of knowledge production which uses post-structuralist theories of language, subjectivity, social processes and institutions to understand existing power relations and to identify areas and strategies for change.". The manner in which individuals understand and express their experiences is never independent of language (Gavey, 1989). Discourse is a distinct concept, differing from language and text, as such, because it is historically, socially and institutionally specific structure of statements, terms, categories and beliefs (Scott, 1991). Discourse analysis, then, with its' deconstructive analysis of language can be seen as a means of questioning universal categories and critically examining historicized concepts otherwise treated as natural (man/woman) or absolute (equality/justice) (Scott, 1991).

It has been suggested that attention to language which embodies meaning constitution enables alternative interpretative possibilities, and that to ignore such an analysis results in simplified and superficial analysis that ultimately perpetuates conventional understandings (Scott, 1991). This claim is based on the notion that language comprises not merely vocabulary and grammatical rules, but a meaning-constituting system. This system, which is not necessarily exclusively verbal, creates meaning and social practices that enables interpretation and representation of individual reality (own identity) and social environment (relations with others) (Scott, 1991). Language can be seen as the starting point for interpretation and understanding the construction and dynamics of social relations[15].

Inherent within the system of language are the ideological and political

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[15]Word choice and meaning can therefore contribute a great deal to understanding power relations in a particular social environment. For example, how meanings change, what meanings are considered normative and which disappeared, how is meaning acquired, the choice of words a person uses.

investments of competing discourses [16]. This creates a multivocality that either conceals or maybe distinctly shows power relations within the social order[17]. An illustration of this is the tendency for privileging certain types of experiences or knowledge and the invalidation of others that differ[18] within a culture (Reinharz, 1992). Foucault further illustrates this point in describing discourses as "a structuring principle of society" which "represent political interests" that permeate through "written and oral form and in the social practices of everyday life." (Weedon, 1987, p. 125). Knowledge is transient and therefore inherently unstable. It is not neutral, but closely connected with power, so that those benefiting from constitutional power regulate what constitutes "truth" and maintain privileging of material advantage and power (Gavey, 1989).

The issue of power, then, is viewed as central to examination of discursive fields. Foucault's contention that the discourse of patriarchy holds tenaciously to a position of

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[16]Foucault asserts that elaboration of meaning in itself involves conflict and power. Meanings are seen as locally contested in discursive fields. Power to control a knowledge field resides in claims of knowledge (scientific of course!) that are embodied in literature, institutions and social relations. Discourse can therefore be viewed as being contained and expressed in institutions as well as words. All of these things constitute texts or documents that can be "read" or interpreted. Discursive fields overlap, compete and affect each other in an endeavour to assert authority in the search for truths (Scott, 1991). These truths are assumed to be discoverable with correct scientific inquiry.

[17]There is the potential for individuals to identify with a wide range of subject positions within a discourse, but the degree to which identification is complete is a function of the centrality of the subject position to the individual. A divide between subject position and individual interest manifests into a site for political struggle, either in compliance with or resistance to the discourse (Weedon, 1987). Foucault illustrates how challenges to fundamental assumptions have most often been marginalised or silenced, and at the least challengers have down played more radical assumptions in order to gain a short term goal, or have compromised their perspective into an existing framework (Weedon, 1987).

[18]The concept that meaning is created through either explicit or implicit contrast is derived from post-structural analysis. This assumption therefore means that an accepted definition requires regression or compromise of something opposite or antithetical to it. Meaning then, that gender descriptors become intrinsic to cultural representations, are tested, and become established as terms that organise gendered behaviour and thinking within society, and ultimately of course, interpretation of male and female behaviour. The contrasting descriptors are interrelated, each creating, recreating and maintaining the other (Scott, 1991). For instance, historian Jill Matthews constructed definitions of what constituted "normal" femininity to which women would presumably strive by an examination of psychiatric case notes of institutionalized women (cited in Reinharz, 1992).

supremacy that enables the devising of means to resist challenges to itself is consistent with Weedon's (1987, p. 109) assertion that "the most powerful discourses in our society have firm institutional bases". Medical, legal, education, leisure, religious and family institutions assure maintenance and regulation of discourses that enable men, from their constitutive position of power, to fashion a role for women that suits and compliments their needs.

The power of discourse, through creation and maintenance of institutions, and the constitution of subjectivity can be seen in the linking of female subjectivity to reproduction in the tradition of Western scientific discourses. Foucault (1978, p. 104) asserts that "the female body was analysed - qualified and disqualified - as being thoroughly saturated with sexuality". This scientific discourse which creates gendered categories according to reproductive ability also creates distinction in social position between male and female. The reproductive function of being female relegates women to the private sphere while men exist in the public sphere, controlling and maintaining the discourse of patriarchy. Furthermore the emphasis placed upon women's reproductive role within the discourse of patriarchy is not based upon evidence of a biological or social need. Indeed, for a number of women reproduction is not desired and for others, it is not physically possible[19].

What is critical about the examination of abortion services and women's reported experience of abortion is their occurrence within a discourse that values highly the reproductive role of women. The issue for the current research is the extent to which the discourse of patriarchy influences the identification of the experience of abortion by women. Therefore, the nature of the interviews in the current study is also critical in breaking down patriarchally defined roles frequently assumed by the researcher and the

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[19]The discourse of heterosexuality is in the interests of patriarchy as it is "based on the oppression of women by men and . . . produces the doctrine of difference between the sexes to justify this oppression" (Wittig, 1992, p. 20). It therefore assures biological sexual identity is reinforced through socialization processes that provide distinct and separate hierarchical subject positions (gender roles).

researched. In the following section, feminist methodology used in the current research is presented.

CHAPTER FIVE

METHOD AND METHODOLOGY

Doctor:[reading case notes] 'Ah, I see you have got a boy and a girl.'
Patient:'No. Two girls.'
Doctor:'Really. Are you sure? I thought it said . . . [checks notes] . . .
Oh no, you are quite right -two girls.'
Patient/Doctor interaction in England, recorded by Ann Oakley.

Feminist methodology: Research in mainstream psychology has predominantly been conducted from a male perspective (Denmark et al.,1988) and subsequently has either taken research findings derived form studies using male subjects and generalised to women or compared women to a male norm or standard (Klein, 1983). Feminist researchers have attempted to balance the androcentrism of mainstream research by directly addressing the bias and developing new ways of validating, analysing and explaining women's experiences. It must be noted that feminist methodology is not a homogeneous concept as various styles, methods and rationale have been used by women conducting social research from a feminist perspective (Klein, 1983). However the underlying assumptions within feminist method and methodology are generally the same.

Researchers taking a feminist perspective generally reject, or become critical of the 'objectivity', experimental approach and quantitative data gathering of the positivist paradigm. Rather, they have tended to design research using qualitative data collected in interviews or by observation, emphasising the importance of women's interpretation and validation of their own experience. This point illustrates the conflict between the two 'schools of thought' over what constitutes an authoritative source of information and what is viewed as 'truth'.

Feminist methodology then, denotes a change in emphasis from information gathering and asking the "right question" to interaction, attentiveness and focusing on the process and the views of the participant (Anderson & Jack, 1991; Harding, 1986; Harding, 1987). Anderson and Jack (1991), in their book *Women's words,* draw attention to the freedom and flexibility in the semi-structured oral interview, firstly for the researcher, to

whom it gives quality responses to work from, while at the same time it does not require the "questionnaire" to anticipate all eventualities. As for the participant, it allows the presentation of their experience in their own words and in their own way. This process also ought to eliminate the effect of experimenter demands where the women may present experiences within publicly acceptable terms, in accordance with their perceptions of the experimental aims resulting in their reality being muted by dominant male concepts and values (Anderson & Jack, 1991). Additionally, it enables the researcher to attend to emotions that are outside and within the bounds of "acceptability" , especially those that are hard to detect, and not only to examine them separately, but also to look at the interaction between them.

This approach acknowledges that knowledge (scientific or general) is socially constructed and that research can never be completely value free as the researcher's life experience and value system will effect how the research is conducted, the questions that are asked and the way the information is interpreted (Oakley, 1981). It is possible that the interviewer's own goals affect the nature of the interview and the information that is elicited. It is therefore vitally important that the interviewer is at all times conscious of their role. Interpretation is a further area that is affected by the expectations and goals of the researcher. For this reason it is important to continue contact with the participant, discuss transcripts of the interviews and involve them in the interpretation.

All research has some impact on participants , and feminist research strives to contribute either directly or indirectly to social change broadly defined and to the empowering, knowledge or conscious raising of the participants[20] (Mies, 1983; Oakley,

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[20]Oakley (1981, p. 41) asserts that an interviewer ought to be "prepared to invest his or her own personal identity in the relationship". This concept that researcher self disclosure within the course of interviews is "good feminist practice" (Reinharz, 1992, p. 32) is problematic. There appears to be no single feminist perspective on researcher-participant relations and the role of researcher self-disclosure and the possible meanings and implications of these phenomena (Reinharz, 1992). However, the assumption that the researcher is able to empower the participant has the potential to be buying into 'patriarchy. This notion assumes that the researcher can posses knowledge about the womens' experience that she cannot, and this surely is inherently hierarchical. Rathgen

1981). In a masculine model of social research and society the interviewer and the participant are "socialised" into assuming the correct interviewing behaviour. This process depersonalises those involved, creates a hierarchical relationship between the two people and encourages a one-way sharing of information (Oakley, 1981). This process negatively affects the validation of women's subjective experiences both as women and as individuals in society.

Women generally respond to the interview process by disclosing/sharing many personal details and perceptions. It can be viewed though as a form of coercion because once they begin talking they get involved in the topic, and with a skilled listener/interviewer, reveal more than was probably intended. It has been suggested that this form of research is a form of social therapy, but counter to that it must be acknowledged that all interactions impact on an individual to some extent and this process is no exception.

Women's expression of their perspective has often been "unheard" especially in situations where their interests or experiences differ from those of men (Anderson & Jack, 1991). It would follow that experiences which have fallen outside the boundaries of acceptability have not been accessed or addressed. The most central of "unheard" experiences must be those pertaining to reproduction, such as contraception, abortion and child bearing, where the potential for individual experiences to fall outside male formulated and defined acceptability or normality is great.[21]

Just as the method of obtaining information affects the quality and type of data produced, the language available to describe experiences both in the reporting by participants and in interpretation by researcher is a crucial aspect of understanding the

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(1995) states, upon the completion of her research, that reflection "has made me wonder how interested the women were in my investing my personal identity into their lives? After all, I had invited the women to talk to me about their experiences, their points of view, they had not invited me to talk to them about mine.".

[21]Men, no matter how empathetic, can have no personal experience to inform their theory and investigations in this area.

experience of abortion and the system it occurs within.

The present study investigated the experience of a small number of women who had a termination of pregnancy, a group which it can be argued, has marginal status by virtue of their gender, age and social attitudes to abortion. The women interviewed were expected to feel disempowered by a combination of these factors.

Participants: All participants were women who had not intended to become pregnant and upon learning of the pregnancy chose not to continue with the pregnancy, but to abort. The terminations were not on medical grounds.

Thirteen women aged between nineteen and forty years were interviewed. Th e participants were divided into two groups - those who had undergone a termination of pregnancy more than six months before the interview (part one) and those who were interviewed prior to a termination of pregnancy as well as following it (part two). Nine subjects in part one all had a pregnancy terminated more than six months previous to the interview. Four subjects in part two were pregnant at the time of the first interview. They were interviewed twice following the termination. All participants in the present study were Pakeha New Zealanders. Seven women were living in flatting situations when they became pregnant, six were living at home with their families or extended families. One woman was unemployed, two woman were full time mothers, three were completing tertiary training, and seven were in paid employment at the time of the termination. Of the participants in paid employment three had tertiary education.

Procedure: Participants were contacted through Family Planning Association[22].

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[22]Participants were not able to be obtained directly through Lyndhurst Hospital, Christchurch. It was communicated to the researcher by the medical director that: (a) there was no requirement for research into the area of personal experience of abortion and experience of abortion services, and (b) that women having terminations were too distressed to participate in research.

Participant selection: Medical staff at Family Planning Association[23] asked women who were eligible to participate, if they wanted to be involved in research. The women in part one were approached by a general practitioner who, in the course of the consultation, noticed that they had previously terminated a pregnancy[24]. The participants in part one of the study all had a pregnancy terminated more than six months ago.

The women in part two were contacted through the referral agent (general practitioner or certified consultant), whom they saw prior to the termination of their pregnancy at a Christchurch abortion clinic (Lyndhurst Hospital). It was explained that their decision to participate in the research was in no way related to their acceptance for the abortion or their treatment throughout the procedure. Participants in part two were interviewed prior and subsequent to the termination.

Women were asked if they wanted to participate in some research about how women feel about their abortion experience so that feed back on the procedure could be obtained The women were given information about the study (Appendix A or B) prior to agreeing to participate. The twenty one women who indicated agreement to be involved in the research had their medical file number recorded in a ledger. Participants either indicated that they would contact the researcher or if they wished to be contacted. Nine participants indicated that they would contact the researcher, only one made contact. Contact was made with the twelve women who indicated that the researcher contact them by accessing personal details on their medical file. The nine women who declined to be involved in the research were also recorded on the ledger. Once contact was made the

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[23]The researcher attended a meeting with medical staff at Family Planning Association, Christchurch, to explain the rationale for, and purpose of the current study prior to the recruitment of participants. The medical staff then had the opportunity to clarify issues about the research.

[24]The selection of participants was entirely at the discretion of medical staff. This resulted in several problems in terms of participant numbers and bias. The procedure required that medical staff noticed the previous termination in the first instance, and secondly that they asked the women if they wished to participate. Several members of staff declined to ask patients if they would participate in the research for personal reasons, and another refused to ask women whom she felt were upset about the abortion.

participants met with the interviewer, read and signed a contract agreeing to mutual confidentiality. The interviewer asked the women for permission for the interviews to be recorded, and signed a contract regarding confidentiality (Appendix C).

Interviews: All participants were interviewed informally by the writer. Interviews were loosely structured, and took between 15 minutes and 2.5 hours to complete. Participants were offered a choice of venues. Five were conducted in the researchers home and eight at the participants home/ flat. In all instances interviews were conducted privately with no other people present. All interviews were tape recorded, and transcribed at a later time. Once transcriptions were made, and the data collated the tapes were erased.

Each participant was asked to talk freely regarding their experience of abortion and the issues surrounding it, with the interview schedule (Appendix D) being used as a guideline by the researcher. There were no structured questions in the interview schedule, and in some interviews the women, during the course of conversation, covered most of the areas listed in the schedule without prompting. Some responded, however, by talking more freely when they were asked questions about specific topics.

Data analysis: This feminist post-structuralist method of analysing construction of meaning and relationships of power employed in the present study in data analysis draws on discourse analysis (Scott, 1991). Transcriptions of the interviews constituted the data in the current study. Analysis of transcriptions required the separation of the narratives into sections reflecting the structure of the interview schedule. The process of analysis involved two steps. The first was an examination of the narrative content and involved identifying key themes. Qualitative data was summarised in this way, and analysed under the following four main themes:

- DEMOGRAPHIC DETAILS
  - age
  - ethnicity
  - previous parity
  - previous termination(s)
  - contraceptive use/ type
  - educational and/or career development/ plans
  - relationship issues - single, divorced, separated, married, de facto
- PERSONAL ISSUES
  - social support - partner, family, friends
  - feelings/ experiences; before, during and after termination
  - feminism
  - decision making
- MEDICAL ISSUES
  - pain
  - procedure - expectations, information, support, education
  - local vs general anaesthetic
  - surgical termination vs self administered (RU486)
- SERVICE ISSUES
  - counselling - prior to termination
  - experiences with certified consultants
  - information - availability, appropriateness, accuracy
  - accessibility - support

In analysing the information gathered a summary of each of the above themes was made. As far as possible the participants' own words have been used in reporting findings, accompanied by commentary by the researcher. The second step involved in data analysis was an examination of the ways in which the experience of abortion was understood by the women through the exploration of language. Language reflects the influence of social forces, and the commonality between different women's narratives means that some tentative generalizations can be made regarding these[25].

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[25]Despite the methods used to determine key themes within and across the women's narratives in the current study, the selection process determines the relevance and therefore inclusion of text, raising the issue of who controls the text. The collaborative research process then, can also be viewed as problematic.

Content and discourse analysis were employed to interpret the narratives and the following tendencies were expected to emerge:

- That following a termination of pregnancy some women experience negative disruptions in daily functioning that are not severe or of clinical significance but have an impact on their lives and functioning, a minority of women experience severe adverse psychological responses, and a majority find it to be a positive experience.
- That younger women are less satisfied with their abortion experience and have different needs/expectations than older women.
- That there is a broad pattern of coping behaviour that women engage in when faced with the choice of a terminating an unplanned pregnancy that is different to coping behaviour in response to other negative life events.

CHAPTER SIX

WOMEN'S WORDS: FINDINGS OF THE CURRENT RESEARCH

Interpretation of the narratives: Analysis of the interviews involves consideration of themes across interviews and discourse analysis within and between interviews. A brief description of each participant in the current study is presented. The participants responses are presented in a thematic arrangement, with a brief commentary from the researcher.

Demographic details:

Part one: Women who were interviewed at least six months following a termination of pregnancy.

SARAH is a twenty three year old Pakeha, living in a flat. She has a Bachelor of Arts Honours degree in Education. She is currently working in a retail store. Her termination occurred three years ago when she was twenty. Sarah and the father separated immediately following the termination

MANDY is a twenty three year old Pakeha, she lives in a flat with her three and a half year old daughter. She left school at the end of her sixth form year. She recently lost her job as an accounts clerk for a real estate company. Two terminations were six and thirteen months ago when she was aged twenty two. Mandy separated from the father following the second termination.

RONNIE is a twenty year old Pakeha, living in a flat. She is currently studying towards completion of a Bachelor of Fine Arts. Her termination was nine months ago, she was nineteen years old. Ronnie separated from the father when she learned she was pregnant.

ELLEN is twenty four, Pakeha, and living at her parents with here two year old daughter. She has a Bachelor of Arts degree in sociology and education. She is currently employed as a receptionist. The termination was six months ago when she was twenty

four. Ellen separated from the father when she learned she was pregnant.

ANDREA is twenty three, Pakeha, and living in a flat. She has an Honours degree in art history. She is currently working for a large multinational company. The termination was twelve months ago when she was 22. Andrea separated from the father about four months after the termination.

JOAN is thirty two, Pakeha, and living with here partner. She left school with University Entrance and currently has a managerial position with an export company. The termination was nine months ago when Joan was thirty one. Joan is still with the father.

EMMA is twenty, Pakeha and living in a flat. She left school after completing sixth for certificate. She is working in a supermarket at present. The termination was six months ago when she was nineteen. Emma was not in a relationship with the father, and he was not aware that she was pregnant.

JOY is twenty, Pakeha and living at home. She left school after the seventh form year. She is currently employed in a travel agency. The termination was eight months ago. Joy separated from the father several months after the termination.

SUE is forty, living with her partner. She left school after attaining University Entrance. She has completed tertiary training. She is currently involved in working with offenders. The termination was 5 years ago when she was 35. Sue is now in a long term relationship with the father, the pregnancy was the result of an extra-marital affair with him.

Part two: Demographic features of women who were interviewed prior to a termination of pregnancy, and following it.

JENNY is twenty three and living at her parents with her twenty month old daughter. She is currently a full time mother. Jenny is not in a relationship with the father.

RACHAEL is twenty three and living at her parents. She is at polytech studying electronics. Rachael is in a long term relationship. The father could possibly have been someone other than her partner.

KATE is nineteen and living with her parents. She is currently involved in the performing arts. Kate is in a long term relationship with the father.

POLLY is twenty one and living with her parents and her two year old son. She is currently a full time mother. Polly separated from the father (who is the father of her son) shortly after learning she was pregnant.

Contraception: Participants in the current research talked freely about their use of and beliefs about contraception available to them, often about their experiences relating to sex and about how they believe they became pregnant. The women all reported being sexually active for some time before they became pregnant, and had some experience of contraceptive use. None of the woman participating in the present study reported deliberately setting out to or deciding to get pregnant. Of the thirteen participants in the current study, three reported using a birth control pill, while six reported using condoms as a contraceptive at the time they became pregnant. Four reported using no or infrequent use of contraception, but reported believing that pregnancy was not likely to result.

Sue had not had a sexual relationship with her husband for about five years due to his suffering from a genetic disorder. She described getting involved with a man, and believing that pregnancy couldn't happen to her:

> So anyway, I ended up having unprotected intercourse and got pregnant, which in hindsight sounds stupid because I have always taken care of myself, taken care of my body.
>
> The whole thing [reproduction/abortion] is your choice anyway, but it's even more your choice if you are taking care of your own body and doing it in your own way.

Kate, during the course of her narrative accepted responsibility for contraception. Kate explained that her previous experience of taking the contraceptive pill had influenced her decision to use other methods to prevent pregnancy. When asked what methods of contraception had been used at the time of conception she stated:

> Well none, really. I was pretty irresponsible, occasionally, I was using condoms or natural family planning. But I'm not a big supporter of the pill . . . just from previous experience of the side effects and things . . . after this I'll probably go for something like the IUD.

Rachael and her partner were using condoms at the time she believes she got pregnant:

> I was, it sounds really funny actually, it's not something you really talk about, but my boyfriend at the moment doesn't ejaculate so we don't use any. It's kind of weird actually . . . so if it was him [who was the father] I would have been pregnant before. But normally condoms, but they gave me some pills at the clinic, it's more safe than condoms.

Jenny accepted personal responsibility for the pregnancy:

> . . . but I'm going to be sensible now and I'm back on the pill. Mind you, I got pregnant [before] when I was on the pill"

Sarah felt that her use of condoms was not believed and that was the reason she was told to go back on the contraceptive pill.

> They put you back on it [the pill] . . . I mean the reason I got pregnant was a failed contraceptive and it wasn't as though I was running around like a rabbit. We were using condoms. I mean I hadn't done anything stupid and caused it myself, and it was as though the doctors didn't believe me. They said "Oh you weren't using contraceptives".

Ronnie, like Sarah felt that her reporting of contraceptive use had not been believed by medical staff at Lyndhurst:

> I was using condoms. I don't think they [the doctors] believed me. It's like they thought I'd done it [got pregnant] on purpose.

Joy and her partner had been using condoms around the time that she got pregnant. She had recently stopped taking the oral contraceptive pill as she felt she had gained weight while on it, and suffered migraines and experienced mood swings.

> I didn't like using condoms much, but I couldn't stay on the pill. I felt so bad, I felt bad about my self and the way I looked, and our relationship was affected

Ellen accepted sole responsibility for the pregnancy:

> I guess I was a bit, um, well a bit irresponsible. I just didn't think I would get pregnant."

Andrea also indicated that she assumed complete responsibility for being pregnant:

> We were just fooling around and um, maybe we weren't, well obviously, I wasn't careful enough.

As did Emma:

> We used condoms. I guess I just used them wrong.

Joan reported regularly taking the contraceptive pill during the time that she conceived:

> I was on the pill. I'm not sure that the doctor I saw [at Lyndhurst] believed me. I guess they must hear a lot of women saying they used contraception and still got pregnant. I know I took them religiously.

Mandy experienced strong feelings of self-blame and embarrassment about getting pregnant again. She felt sure that she had taken the pill consistently during the cycle that she conceived. Mandy felt that taking the pill was as much a part of her morning routine as putting on her make-up, that she would have felt as she did if she had no lipstick on if she had forgotten to take a pill one day.

> Each time I've been pregnant I've got pregnant while I've been on the pill. The second time I got pregnant it was a complete and utter different feeling, I feel so stupid for being pregnant again, um, you know, I felt embarrassed going to the doctor at family planning, you know I felt really awful going to Lyndhurst again.
> I just felt terrible. I was in tears the whole time and couldn't talk to anybody about it.
> She {the doctor] said you know if you are telling the truth , you were on the pill . . .

Polly also reported taking oral contraceptive's when she became pregnant both times:

> The doctor [at Lyndhurst] said it was a miracle to get pregnant on the pill twice, but I did it.

Women in the current study consistently accepted responsibility for the unplanned pregnancy, as can be seen in their use of the personal pronoun "I". The reports of contraceptive use were frequently doubted by medical professionals. The unwritten rule

that women begin taking the contraceptive pill following a termination gives a clear message to these women that they are not capable of using contraceptive options effectively. This is especially true when considering that, in percentage terms, the oral contraceptive pill is no more effective than the combination of spermicide and condoms. Although in practice oral contraceptives may have lower failure rate due to poor understanding of how to use other methods of contraception correctly.

Decision to terminate and influence of fathers: The term "father" is used to describe the male partners of the women in the current study who were the biological fathers of the babies. Of the thirteen women interviewed, twelve were neither married or intending to be married to the father at the time of termination. Only two of these participants were in an ongoing relationship with the father at the time of the interview and one woman had become pregnant as the result of a casual sexual encounter rather than in the context of an ongoing relationship. All of the other women had separated from the father either shortly after they learned they were pregnant, or soon after the termination. One women was married at the time of the termination, at the time of the interview she was in a long term relationship with the birth father, the pregnancy was the result of an extra-marital affair with him.

Deciding whether to keep the baby, relinquish it for adoption, or to abort was not an easy decision for any of the women, and was affected by idiosyncratic and similar situational factors. The decision to terminate an unplanned pregnancy for the women in the present study was reportedly made for two main reasons;

(1) The need to complete training or to undertake career opportunities that would not be possible to attain with a baby.

(2) And/or the acknowledgment of their lack of financial resources, and desire not to parent without a partner.

Joan believed she had the support of her partner in her decision but learned after the termination that he would have liked them to have had the baby:

> I sometimes think he wishes we had a family. Lots of his friends have, and he loves kids. Sometimes friends you know, ask when we are having a family, and he, well he gives me this look of, well, you know you had your chance. Actually he does it most around his mother, like I've deprived her of grandchildren, Dave's an only child. It's not as though I never want to have a family, it was just the wrong time in my life. Dave knows that.
>
> Dave came to Lyndhurst with me. He wanted to come. He knows what happened to me then.

Joan discussed perceptions of motherhood, and how her reluctance to embark on a journey into motherhood is due to perceptions of the personal sacrifice it entails.

> My mother didn't have a choice, she just had children. My mother gave up a career, she was a dress maker, for us, she devoted her whole, her whole life to my father and us, and now we have left home, have our own careers and lives, my sister is married and has children, and you know, my mother has nothing, she depends upon father and us for her interests and validity.

When considering options available Joan was conscious of the effect that having a baby could have on her career and the change to their financial situation.

Andrea separated from the birth father several months after the termination, and recounted feeling that he would not be around to share the responsibility of parenthood.

> He couldn't cope with the idea of responsibility. He, well, he wasn't keen on commitment to put it mildly. I don't know if we would still be together if I hadn't got pregnant, but we might have, I don't know.

Andrea had recently attained what she viewed as a career job, and felt that she may lose that opportunity if she were to have the baby. She felt, like other women in the study, that it is important for a child to have the involvement of both parents, although she believed she could have coped as a solo parent, she did not want to be one.

> My career was just starting, I couldn't take time off, and anyway, I didn't want it to have no father [involvement].
>
> There are women who love the whole idea of pregnancy, the image of mother and child, and that sort of thing, but that is just NOT me.

Other participants in the study had either already separated from the father or

reported being aware that it was more likely that they would separate in the near future than it was for them to remain together. The partners of these participants influenced the decision by their absence or by their withholding of involvement.

Mandy recognised that her relationship with the father was not stable, and not likely to continue. This is especially apparent as this was the second pregnancy in the space of seven months that she chose to terminate:

> We didn't want to have any children and then I got pregnant and it was like, I knew straight away that I wasn't going to keep it . . . You know, I'm going out with this guy but there is no commitment there, you know I'm not saying that I am going to be with him two months later. If we were very secure, very safe in our relationship, then I would have had the baby. I said, I'm a single mother now and I don't want to be one again with another one.

> I started realising it was a possibility that in the future I would be a single mother with two.

Mandy's partner left the choice up to her and did not participate in the decision making process, but, by doing so, he influenced Mandy's decision.

> There was actually two weeks where we decided we [would keep it] . . . I thought all the reasons were wrong . . . he just sort of said , well you know, whatever you want I'll be there.

Mandy recounted feeling unsure of the decision to terminate and stated that if her partner had wished for her to continue the pregnancy, she would have done so. It is clear that much of the reasoning for not proceeding with the pregnancy depended upon the response of Mandy's partner. To Mandy, he is in effect controlling the decision, and Mandy appears to have no power or autonomy in the relationship. She is dependant upon him, and is desperate to hear him say that he wants to commit to her and to a child. She reports being unsure up until the termination was about to be done:

> They were saying "are you crying because you are upset and nervous or are you crying because you are not sure?" and I wasn't about to say well "I'm not sure because" . . . They would have gone *whit* (motions) out of here.

> I wasn't, I actually wasn't going to take them [prostaglandin tablets]- if he'd said to me at that point, I don't want you to take them, I wouldn't have, but he didn't . . . He says, you know its for the best, and so I took them. I'd told him that's [the abortion] what I want, yet at that point if he had said don't take them I wouldn't have, I'd be pregnant now.

Mandy felt that she was not a particularly good parent. She believed that she should like her child unquestionably, but that was not the case and Mandy often felt resentful of her child and guilt for feeling this way.

> I'm not the most paternal [sic] person in the world, and I mean, I've got my daughter and I love her to death, but I don't like her very much.

Like Mandy, Polly's partner had left the choice up to her, and she felt that he was avoiding making commitment with her, especially as they already had a child together. They separated before the termination, and Polly reported the limitations of solo parenting and personal goals as reason for her decision:

> It was hard before we split, you know, financially, but on the D.P.B. I would have been in the financial dog house with two . . . I like to buy my son toys, and you know, go out with friends . . .
>
> I was thinking about going back to Tech, I can get a child care subsidy for Jordan.

Jenny also has a child already and acknowledged the difficulties of parenting alone, and how this affected her decision making process for this pregnancy:

> Not by myself, not with two. Oh it's hard enough with one. I couldn't cope with two by myself.

Ellen also found that once she learned she was pregnant the father wanted nothing more to do with her, leaving her with the responsibility of the decision.

> He, um, he said he never wanted anything that was like serious. I guess he, um, never thought much of our relationship.
>
> He's got his new girlfriend pregnant now.

She also believed that parenting alone was not an option for her, and that she had first hand knowledge of the demands of this situation.

> There's no way I could've done it . . . not without a partner, um and already having one I know what it is all about. Having my daughter changed my whole life . . . completely changed everything.
>
> It sounds selfish, but I could never go through all the hassles of being fat and pregnant, and all that pain to give the baby to someone else.

Ronnie was beginning a degree in fine arts at university, and felt she would have to forfeit her studies and goals to raise a child.

> If I had a baby, it would be like, forget my art, forget my career, forget the rest of my life. That's what would have happened. Having an abortion's like, well it's like using a condom in a moral sense [in that it prevents a baby], it's just more effective that's all.

Ronnie was aware that she would have no support from the father, as they separated shortly after she learned of the pregnancy.

> He didn't want to see me after I found out, but um, he was a bit of a creep anyway. I couldn't, um, contemplate having a child on my own, not without support, no. I haven't got the maternal instinct at all.

Sarah also highlighted the need to complete education as a reason for choosing not to continue with the pregnancy along with the financial limitations of raising a child on her own.

> I had a fairly good idea that I was [pregnant] . . . I'd already decided in my mind that I was going to [terminate].
>
> He um, put the pressure on me and split up. The day afterwards he said, well I've helped you through it, you know, break away and leave you to it. [He said] I've done my bit, which I don't think he quite understood that his bit hadn't even started.
>
> [abortion was] the realistic thing to do because I was halfway through varsity and I wasn't all that keen to support a child on my own.

Rachael, Sue and Emma did not disclose the pregnancy to the father, and from their narratives it is clear that their perception was that the father would be less than supportive. Emma became pregnant following a casual sexual encounter, and she reported feeling unable to tell him about the pregnancy:

> He [the father] don't know, I had, I didn't have enough money for a baby on my own.

> I didn't know him very well, we weren't, well, we weren't really, he was just a friend of a friend. He wouldn't want to know about it . . . probably wouldn't believe me.

Sue recounted experiencing extreme personal stress at the time of conception. For six years she had worked in paid employment while also nursing her sick husband at home. When he was hospitalized, she experienced a period of major transition in her life.

> I was seven and a half stone, I was chain smoking, um, I was majorly stressed out . . . so it was kind of like after he went into hospital I went completely off the rails [cries] . . . so my reaction to all this was to spend a lot of nights getting completely drunk and then I got involved with one of the guys from work, um who was going through a similar time with his wife, his marriage had just broken up . . .

The option of abortion did not occur to Sue, as an outcome for the pregnancy, until it was discussed with her by her general practitioner, even though she had suspected pregnancy before missing her menstrual period (giving her about two weeks to have considered options).

> I was about a week overdue when I went to Family Planning. Termination had never entered into my head, I had never thought about it as a possibility, and I went and you know, had the pregnancy test, and the doctor there said, had I considered termination as a possibility, so um, that had never even entered my head. I'd always been pro-choice, believing that women should have that right. But of course it is always someone else.

Although Sue disclosed the pregnancy to the father over a year after the termination, at the time she chose not to tell him:

> I mean it's a devastating decision. When Gillian, the doctor mentioned it, I thought, hell I hadn't even considered it. My reaction was, how am I going to manage, you know, bringing up a child on my own . . . how am I going to work everything out . . . and there was no way at that point, that, that I would have had any support from the father, it wasn't possible, in fact that's the reason I never told him, because he had enough to cope with at that time.

The need to make a decision led Sue to discuss with a friend who had terminated a

pregnancy, her experiences, and also to draw upon her perceptions of solo parenting in New Zealand:

> I thought about it, how I could manage with a child, like I say, I've been around a fair bit through my job . . . and I'm aware that it's not all like the Lux soap adds or anything, there's some real real down times in being a solo mum. But it's like I say, in hindsight I couldn't have coped, I really couldn't have. I had along way to go with myself.

Rachael had a brief relationship with the father during a time that she was separated from her current partner.

> I was actually going out with this guy and we broke up and everything, and I met this other guy and he, I think the babies to him [that he is the father], and he ended up being a real jerk, and I don't want to see him at all, and in the mean time I got back with the other guy, so I don't want to say anything . . . I haven't told anyone at all. But I think it should be alright, it's my body.

Rachael felt that the views of other people would be too much to cope with if she were a solo parent. This resulted in her making the decision on her own, but drawing on perceptions of what being a parent alone would involve.

> I don't want to tell other people because some people are kind of judgemental, you know, if someone's pregnant or having a baby, they're like well where's the father, some people are just really judgemental. I don't want that at all. They say things like, oh, you're a real tart and things like that.
>
> But the reason that I wouldn't want to have the baby, the reason that I wouldn't want to adopt, cause then everybody would know and they'd be like, whose is it? And also it really scares me you know, the whole birth process, arrgh. Also it's that, well, I don't really, I'm trying here, but you know, we don't really eat a hell of a lot and my lifestyle is not very good, you know I think with a baby inside me, you know, I'm not looking after my body.
>
> I've got a friend at the moment, she's young, she's nineteen and she's by herself, and she's got no life, she's always home . . . she's got to look after him and she's not going to have anything for herself, so you know it's a real shame.

Rachael felt that she needed to do things for herself before having the responsibility of a child.

> I want to travel again, I want to have money and a job, and a relationship [when I have children].

> I knew, there's no way I want to have this baby, you know you say that people are too young at nineteen, or whatever, and I'm twenty-three, and lots of people have kids at this age, but I still feel too young, there's so much more to do.

Kate had been in a relationship with the father for six months and reported having his support in her decision making process, but indicated that she did not need the support of others. This perception is interesting as in disclosing the termination to friends there is quite probably a form of social therapy occurring.

> I didn't really feel like I needed too many people around me, um, my boyfriend came with me. He came with me and was there all the time...I don't really need support. I've told just about everybody I know, um, people at school.

> [I knew] automatically, its, its just one of those things that don't cross my path at all for many years. I'm not really the kind to be on the D.P.B. and sit around for the rest of my life being a mother . . . I don't really like children anyway and I can't see myself as that kind of maternal person . . . and also the age thing, I mean I'm very young and I've got tonnes of things I want to do before I even think about it, I mean at the moment it's just a completely non-issue.

The fathers in the present study were most noticeable by their absence. The responses of the fathers varied form negative to unhelpful to the decision making process. In some cases absence of the father was the result of the woman's choosing not to maintain contact, but for some participants the father had chosen to stop contact.

It is apparent that the fathers have some degree of choice about their involvement in the outcome of an unexpected pregnancy in the current study, with many choosing to defer responsibility to the women. This freedom to chose is in striking contrast to the predicament of the women when they found themselves unexpectedly with child. They were forced into making decisions about whether to keep the baby, relinquish the baby for adoption, or elect to abort.

Perceptions of the options other than abortion often affected the decision made by women in the current study, with some perceiving that they had more control over their circumstances than others.

Support from significant others: Many of the women reported little or no support from the father. The supportive role of friends and family appears to have buffered the effect of lack of partner support on women's post-abortion adjustment in many cases.

Andrea and Ronnie both reported receiving quality support from their mothers and friends:

> My friends pampered me. Two friends had done it themselves, had an abortion, they were really good to talk to.
> Mum was great, she, well she would of liked a grandchild, all her friends have grandchildren, but no, she was great (Andrea).

> All my friends know. They were terrific.
> Mum knows and that was great. She's quite liberal like that (Ronnie).

Jenny also perceived complete support from friends and family:

> Mum and my sister know, everyone knows, . . . but you see I haven't needed any [support]. It's just that it's what I wanted to do.

Kate had the support of her partner, but also reported having the support of her mother and her friends:

> Mum came home and brought me some flowers.

Several of the women, reported mixed reactions from friends and family, and religion was indicated as an issue for themselves and / or their families. The reporting of the effect of religion by women in the current study is included in this section as it appears to be intrinsically linked to their perceptions of being able to seek support from significant others.

Sarah's family's religion prevented her from disclosing her experience to them and from seeking support from them:

> I had a lot of support from friends, but . . . I didn't have friends who had already been through it.
> None of my family knows. We're Catholics, well mother's a Catholic . . .
> She's an anti-abortionist.

Ellen felt that her sister gave her the most support during the time of the termination.

> None of my friends understood really, they all, well they're in relationships

> that don't have children.
>
> Mum doesn't know, but, um, my sister came with me, she was great. Mum goes to church, but none of us do, not since we were kids . . . Mum's pretty much old school, you know, if you take the risks you have to live with the consequences sort of thing.

Emma felt that she couldn't tell her mother as her mothers religious beliefs would mean her mother would judge Emma's behaviour and that she would not be supportive of her experience. Emma's friends did not offer much support, possibly due to their personal lack of experience and /or knowledge of the process of abortion.

> My friends didn't um, the ones I told, they didn't say much, you know, didn't talk about it or nothing.
> Mum doesn't know. She would think I was too young to have a baby anyway, but anyway, she wouldn't approve of abortion. Mum's catholic. She doesn't know."

Mandy talked about the choice of abortion with her mother, who supported her by listening. She did not discuss the situation with her friends.

> I didn't really tell many people. Only people that knew I was pregnant, and I just told them that I lost it.
>
> First time around I never told my father, my father's a Catholic . . . you don't have abortions and stuff like that. My mum, she never really advised me anyway, she just said whatever you want. Kay [sister] said good on her, I didn't think she had it in her."

At the time of the termination Rachael had not disclosed the pregnancy to any significant others. Rachael did not tell her partner any thing about her experience until after the termination (he was not the father), as she felt he would judge her actions and decision, the father was also unaware that she was pregnant and she did not disclose to friends or family.

> No, the reason why is Dad's kind of funny, I wouldn't want to tell him you know. I wouldn't worry so much with Mum, but I'd have to tell both of them, I'm not going to tell anyone else you see, and my mum said to me a while ago, that in Australia she has got this friend, and her daughter had an abortion and she didn't tell her. She told some other people and it got back to her mum, and she was really upset because she had told other people and not her.

Religion affected Rachael's personal justification of the experience, and prevented her from disclosing to others, for fear of being judged:

> The only thing that does really worry me about the whole thing is that I'm a bit religious, and that worries me, I feel like I'm being selfish, kind of thing, no, I mean I'm not thinking of the baby . . . I used to go to this church in the States, but [I'm] probably Protestant, but in the States it was Trinity, the Assembly of God. I feel like I'm going against God's wants, not that I'm really that religious, but it is there in the back of my mind.

When Rachael told her partner about her involvement in the current research study, he reacted by telling her she made a mistake in partaking in the research and disclosing about the termination:

> He said that I shouldn't have done something like that, that you might use it against me, to blackmail me or something. I told him that it wasn't like that.

The two older participants in the current study did not refer to family support, probably as it was not as central to their identity and existence (living at home) as the younger women. Joan felt the support of a friend with similar circumstances and values was helpful to her in deciding whether to continue the pregnancy or not.

> I told my closest friend. She doesn't have children. She was great.

Sue valued the support of a friend, but was still very much in a mode of dealing with problems on her own, after many years of caring for her husband without support from the health system.

> I went home and thought about it. A girlfriend of mine had been through the same situation . . . well not the same situation, but she had been through termination essentially to save her marriage . . . so I spent a couple of days with her . . . she didn't really give me any advice, she was just kind of there, which was all I needed . . . No, I haven't talked to anyone about it [since], I haven't felt the need.

Religious beliefs affected how Sue thought she would deal with the abortion, but she was surprised to find that they barely impacted on her coping post-abortion.

> I wasn't brought up as a Catholic, I was brought up as a Protestant, but I had quite a strong religious upbringing. I was really expecting quite a lot

> of guilt and I was quite surprised that I didn't, it was a relief.

Sue would not have taken anyone with her to Lyndhurst, even if there had been time to organise it, but she indicated that if it happened to her now she would, suggesting that the change in personal circumstances would alter her decisions. To Sue the abortion was a private experience:

> It's like it's a very political thing you know, pro-choice, but to me it's a very personal thing, very private . . . It was like, it was me, it was my whole thing, it was my experience, and um, I didn't really like to involve any-one else in it at the time.

It can be seen from the above reports that the families of the participants view abortion differently, with some accepting it as a life choice that they would help their daughter through, and others believing (for religious reasons) that abortion was an intrinsically bad act, and these parents were not involved in their daughters' experience. All of the women, however were affected by their parents' responses or perceived responses (in the instances where the parents were not informed) in some way. For women living independently from their parents the responses of family seemed to be less influential than for those women still residing in the family home. However, the variable of religion complicated this tenancy, in being a major determinant of whether parental involvement in the decision was sought. Personal religious beliefs were also indicated as an issue for two of the women (Sue and Rachael).

Information accessed: All participants reported being given some information regarding procedures, and medical after care. There was no mention of information regarding possible emotional responses following the termination, or what to do if they needed psychological help.

> I think the information they give you is OK, um, I can't remember if they give you stuff to take home and read . . . I kept it all for a long time and then sort of thought that I would get rid of it, sitting in my room.

> They gave you a pamphlet before you actually went in and you read through and that basically explained everything and they got all the girls into a room and told us what was going on.

> They got us together and talked about contraception and everything, and um, told us about what they would do to us.
>
> I knew it all anyway . . . They told us all before we went in, you know, all the, like, contraception stuff.
>
> They told us what was going to happen to us, what they would do, you know, in the operation . . . The nurses said about contraception and the pill.
>
> They said about condoms, and how they do the abortions.
>
> They talked about contraception, infections and that sort of thing, and they, we were told what would happen to us in the procedure.

It is clear that information was given to women in the current study before they had the abortion, but the question is whether or not it was adequate. Three women indicated that the information they received was not ideal, each for different reasons. Mandy relied on the experience of her previous termination in order to know what to expect:

> I missed the talk the second time, I was late . . .

Rachael felt that there was no acknowledgement of the fact that she was pregnant until the time of the termination, and that she did not understand the changes her body was going through, making it a frightening experience.

> The counsellor briefly described to me what was gonna happen, I wish she'd kind of talked to me a bit more because I didn't know, but it was really quickly, then you know [shoo], O.K. see this doctor next . . . I was feeling really tired and stomach aches, I wish she'd said stuff about what was happening . . . They actually showed me a thing of how big the baby is, it quite surprised me how big it gets in a week.

Rachael also said that she felt ill prepared for the operation, and would have liked to understand more about what to expect.

> . . . the operation and procedures, and what's going to happen. They just said you get a needle in the hand, and it takes about fifteen minutes and that's about all.

Sue felt that the circumstances of the termination affected how much information she had access to. Sue raised the point that other women in her situation (where the appointment was brought forward, presumably, to fill a cancelation) might not have had sufficient

information either.

> [I] went along for the first session . . . and they said that the second appointment would be in about three weeks, because I wasn't very far along at that stage, only about six weeks, and . . . um, a week later they rang me, I hadn't had my second interview or anything, so they kind of rang me up at eight o'clock in the morning and said can you be there in half an hour, so it really was a huge rush, and then I didn't have, apparently they go through the aftercare stuff . . . that you are supposed to bring pads and things with you, I mean I didn't have a clue, I just arrived there, I had an extremely brief interview with the surgeon that actually did the procedure, and just got straight into a room with four other women in it.

> [one of the nurses] was quite horrified that I was there on my own and that I was going to drive myself home. I had to stop on the way home and buy a thermometer, because like I say I was totally unprepared for it. I had to ring, she made me ring her to make sure I got home safely.

Experiencing the procedure of an abortion: The women in the current study focused upon different things in their recollection of the operation yet there were similarities in many responses regarding the women's perception of the procedure as a punishment.

Kate focused on the operating room in her recollection of the abortion:

> It's quite bizarre, you know, you go into this room and it's very white. It was a really pleasant room and they sort of had the radio going, and it was just really ironic sort of, hearing old Abba hits while you are lying there in excruciating pain.

Sue's recollection of the operation was a blurr, which is consistent with the whole abortion experience for her.

> . . . again everything was so rushed, I don't really remember terribly much about it.

Emma recounted being surprised at the formality of the routine, and the isolation she experienced.

> I've never been in hospital before, its strange, no one talks much to you.

For Joan, Jenny and Ronnie, the shortness of the operation was a significant factor of their recollection:

> It was really quick, I was surprised, it was like they had just started when they said that's it, it's all over (Joan).

> I wasn't even nervous . . . it was just so quick . . . very much a relief. It was really quick and really good (Jenny).

> It didn't take as long as I thought. It seemed to take, like about five minutes. The drugs make you totally out to it (Ronnie).

Several of the women reported that they perceived that they had done something irresponsible, and waiting to see if the abortion was going to be approved heightened the perception that they ought to be grateful for the opportunity to end their current predicament. It was also indicated by two women that having to go early in the morning made the experience feel very secretive, and several women mentioned the protestors as a negative factor in their perception of the experience. Three women also highlighted that because they were aware of what was going on, this created a perception of punishment.

> They make it like a punishment rather than an, um, something that should be, I mean it's legal. I mean to me it really was a punishment you go through and to make you not want to go through it again . . . If I was to do it again I would never go through Lyndhurst again, I just can still feel that pain. I know exactly, I still think about it and I can still feel it and I've never felt anything so bad in my life. A day of nightmare (Sarah).

> The whole thing seems like, um, like really secretive, like it's still illegal (Ronnie).

> It was like I'd done something really wrong , like, I don't know, like I was a criminal (Ellen).

> It felt a bit like a punishment or something for being a naughty girl. I was nervous, I was, it was like when you do something wrong and you are afraid to ask because you are already, like, in trouble (Andrea).

> I said to my doctor, why don't they put you to sleep, I said is that because they don't want to make it too easy for people. I was quite amazed at how easy I thought the whole thing, you know, really was. For me to sort of get up and sort of go there. The day I went they had protestors and everything and they were really quite nasty (Mandy).

Pain levels during the operation: All participants reported experiencing substantial amounts of pain, with the exception of the two second terminations, one of which was conducted under general anaesthetic and the other after the administration of pethidine. Participants reported not being prepared for the pain, or being given unrealistic expectations of what pain levels are likely to be experienced.

> The pain was terrible. It was so bad. I was spewing my guts out after it.

> The pain was fuckin' awful. I never felt anything that bad before. It [the

pain] made me cry.

I mean I could feel them sort of playing around with me, it really hurt . . . and one of the nurses saying its O.K. just relax, and them giving me another shot.

It was really painful. It was like, like bad cramps.

I was in absolute agony. I'd never felt anything so bad in my life.

It was pretty painful. I did start crying because it did hurt. The second time it [the pain cramps] happened I just started crying.

It was pretty painful . . . the whole physical thing the PAIN mainly . . . pretty awful, the pain . . .

after the abortion you can't feel the pain, but during it, it's right at the beginning when they are actually doing it which is the more painful part. I think they could give it [the pain killer] earlier

I thought it was pretty painful

It was little bit more painful than a smear test.

The pain was the worst part of it. My whole body clenched up with the pain.

Four women explicitly stated that they were ill-prepared for the level of pain they experienced during the operation, and one woman (Mandy) reported that her description of the pain was disbelieved by the surgeon she raised it with.

It really hurt, it, the pain was worse than I thought it would be. I thought that I wouldn't feel it at all"

The pain was bad, I was shocked by the pain, how bad it was.

I don't really get period pains, so I didn't really know what that was like.

Maybe it would have been better if they'd maybe warned you a bit better about the possible pain . . . I think the idea of describing them as mild period like cramps was pulling your leg if I got those every month, God I think I would kill myself . . . I said I thought it was pretty painful, he [the surgeon] said it shouldn't have been, he said it shouldn't have been uncomfortable - it maybe hurts a little bit but not to the extreme you're saying
Um, one thing was, you know they say when you go and have it, it doesn't hurt much and that it's, ah, like bad period cramps or whatever, well as far as I am concerned it was a load of complete and utter rubbish.

Reporting of physical effects other than pain were diverse, but noticeably devoid of the passion exhibited in the recollection of the pain during the operation.

> I came out and just spewed non-stop from the shock. (Sarah)
>
> I was throwing up everywhere, it was gross. I felt really weak, yeah, I was weak and dizzy for a few days, probably the loss of blood. (Ellen)
>
> I felt like shit for the rest of the day, um, and the next day, other than having like a heavy period, it wasn't like anything, I don't know what I expected really . . . I didn't suffer the hormone of ups and downs that I'd been told I may have. (Sue)
>
> I felt fine afterwards, just a sore stomach. (Andrea)
>
> My guts was sore for days. (Emma)
>
> Once the um, actual physical thing was over it was fine. It was just the whole physical thing really, the pain mainly . . . I went back to school the next day . . . After the abortion I had this infection . . . and had to sort of go to the hospital and get admitted and things. I was just in such agony. (Kate)

Emotional responses: The emotional responses reported by women in the current are varied, reflecting the diversity of womens experiences. Most of the women reported feeling mild levels of distress in the period following the termination. Several of the women revealed that the experiences of the unplanned pregnancy/abortion were linked with the culmination of their relationship with the father, while others associated the end of the physical effects of abortion with personal resolution of the experience.

> Afterwards I sort of cried, which was quite a normal reaction . . . I was a bit upset . . . it was the whole emotional stress of it all . . . I didn't have any emotional stress over it at all.(Kate)
>
> I don't know how much of the emotional backlash was due to him and how much was actually due to the operation. (Sarah)
>
> It's just like it never, it never happened, um, like I never did it kind of thing. Yeah, it's much better now, it's good . . . Once I got out it was just a relief. (Jenny)
>
> I don't think about it much any more . . . I cried sometimes for a few days, um, when I thought about it, but really I only think about it sometimes. (Ronnie)
>
> I cried a lot . . . I don't know if it was, I was crying because, um, I wasn't with him anymore, and also because of the abortion. (Ellen)

> Sometimes I would be, I don't know, a bit sad about it, but I don't now. My friend is having a baby in August, that, um, that makes me feel weird. I felt that it ruined my relationship [with the father] . . . Now I feel fine about it, there's no problems with that. (Andrea)

> I was just so relieved that the whole thing was over, you know, the waiting and deciding, and everything. It was just so stressful. (Joy)
> I hate John, I bawled for ages about it. (Emma)

> It was really hard for a while, part of that was because Pete was gone, and I was really upset. I just sat and cried. I couldn't believe it was happening to me. (Polly)

Joan, like Sue felt that the culmination of the physical indicators of the experience coincided with the emotional closing of the experience for them.

> I guess I was sad for a couple of days, but then, after I stopped bleeding it's like it never happened (Joan).

> I felt like it was finished . . . once I had my checkups and everything was O.K. physically, that was the end of it. I felt like I had dealt with it (Sue).

Sue was surprised at how well she coped emotionally following the termination:

> I'd expected, um, because from the time I'd got pregnant there was such a huge change in me physically, that um you know, and emotionally I was quite up and down, and I expected that to carry on. I expected nights of despair and I expected quite a heavy guilt imput because abortion is still very much frowned upon.

Mandy reported feeling more distress following her second termination, especially as for a short while she had been planning to continue the pregnancy.

> The second time I know I was a wreck. I was quite upset for about three or four days afterwards.

Feelings about having had an abortion: All the women in the present study reported that they had made the right choice for the circumstances at that particular time in their lives. Without exception they indicated that they wished they had never had to make the decision, and several women suggested that they wished the circumstances surrounding the pregnancy had been different.

Mandy's strongest feeling about having had an abortion was wishing she had not had to make the decision and go through the experience twice. She found that the second time was much more difficult, especially as the two were fairly close together.

> I'm glad that, um, as far as I'm concerned I did make the right decision. I would rather have never gone through it . . . but I'm not sorry at all that I did do what I did do . . . The first time . . . it didn't really bother me at all, and the second time it did, it really upset me.

Sue recognised that she made the right decision for the circumstances when she chose to terminate, and now that her environmental and personal factors are more favourable she feels ready to consider having a planned pregnancy / child.

> I never have [had second thoughts]. It wasn't the right, it wouldn't have been right for me to have a child at that stage. Now five years down the track and my life's quite different, I would dearly love another child, well I would dearly love a child. But that's a process that we have to negotiate. The father didn't know about all the drama at the time, he does know about it now, he and I are in a steady relationship now.

Responses of the other participants in the current study indicate their personal acceptance of their experience:

> I never regretted it.
>
> It was definitely the right thing to do.
>
> Now, I am so glad I did it.
>
> It was what I had to do. I had no choice
>
> It was the only choice really, I never regretted doing it.
>
> It was the best one to do.
>
> I don't regret having it.
> All I know is that if abortion wasn't available I'd be pretty much a dead duck and I'd be stuck with a couple of kids and I'd be a really unhappy person.

Counselling service use: All participants were aware of counselling services being available at Lyndhurst. Three of the women stated that they did not wish to return to Lyndhurst as a place for counselling. One woman indicated that there was not enough support available. All other participants felt they did not need it[26]. The response to

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[26]Interestingly, previous research has indicated that women participated in counselling prior to and following a termination in New Zealand (Society for Research on Women in New Zealand, 1980). It is not clear, however, whether this altered pattern in counselling seeking behaviour by women is due to a true lack of need, less internal

returning to Lyndhurst for counselling appears to reflect the psychological effect on the women of returning to the hospital, rather than any real perception about the type or quality of service available there.

> I think afterwards, I don't think there is enough counselling support. I wasn't handling it very well, didn't have the guts to go back, didn't feel that it was an open door to go back, and didn't even really want to go back there. I had to work it all out on my own . . . it is too hard to go through on your own (Sarah).
>
> They offered it . . . but no I didn't need it (Jenny).
>
> They told us that, um, if we wanted counselling we could. I didn't need to go back [for counselling] (Ronnie).
>
> No, I haven't talked to anyone about it, I haven't felt the need to do it (Sue).
>
> I didn't want to go back for counselling, not for counselling at Lyndhurst, didn't want to go back. I saw a counsellor, a friend of my mums a couple of times about it [the abortion] (Ellen).
>
> They said we could have counselling . . . but I never needed to (Andrea).
>
> They came and said to us about counselling, but, um, I wasn't gonna go back. I didn't need to talk to them (Emma).
>
> They told me about counselling being available. I never felt that I needed any professional help (Joan).
>
> I don't need any counselling, I felt fine about it , yeah (Kate)
>
> They make it quite clear that you would be welcome there, sort of thing. No I don't think I need to [talk to the counsellor]. I was quite upset about it, and you know, couldn't talk about it or anything like that, but then again I don't think I would have wanted to talk to a counsellor, I thought I'll get over this my own way, I don't want to talk to anybody (Mandy).

Perceptions of operating surgeons: There was a variety of responses regarding the certified consultants, with several of the women indicating that they would prefer female surgeons to be dealing with abortions.

> He [the surgeon] was too old. I couldn't relate to an older man. I don't think he even really cared . . . It should be females. Wether there are female doctors out there who won't do it, or what the story is, I don't know. (Sarah)

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promotion of the service within abortion clinics as a function of cost-effectiveness, or other factors.

All of them were really nice. All of them I've come across. (Jenny)

I didn't like the surgeon he was really abrupt. I don't know why they aren't all female doctors. (Ronnie)

The surgeon was an older man . . . He treated me like I was a naughty schoolgirl or something. (Ellen)

Well the doctor, I had a male doctor at Lyndhurst and he was quite, he was quite staunch you know . . . he wanted to know millions of questions, and he was just, really, because it has to be legal and they have to reason, for the abortion to be legal they have to have good reason for a person not wanting to have a child, so he was very stroppy and very, quick, and very unfriendly. I found him quite cold. But the rest of them were all sort of quite mellow about it. (Kate)

He didn't talk or anything to me. (Emma)

I don't really remember the surgeon, she didn't say much . . . I was pleased she was a woman. (Andrea)

I was glad that the surgeon was a woman . . . relieved. (Joan)

The doctor that actually performed the abortion, I found her quite brisk, quite hasty. I didn't really notice her during the operation, um, just when I went in for the first time before I had the approval of the doctors . . . she was very sharp. (Kate)

It was horrible, even the doctor remembered me, you know he remembered my face, um, and he said to me, oh I won't be doing it the second time but the woman you get will probably give you a hard time about being here again. He said she is quite blunt, to the fact and quite rude . . . But she wasn't. She was quite nice. (Mandy)

Nurses at Lyndhurst: All women in the current study reported that nursing staff at Lyndhurst hospital were helpful and supportive.

There was a woman beside me who was injecting the morphine and stuff.

The staff were really good, really bright and cheerful.

The nurses were really wonderful.

They were really great.

They were brilliant . . . cause they, um, take you through step by step and they're always there.

I had one woman, during the operation holding my hand at my side, which was brilliant. It was just good to have someone there . . . even though I didn't know her.

The nurses were fantastic.

The one who held my hand, she was good.

They were really nice.

Preferred type of anaesthetic: In the current study some of the women indicated they would prefer to be under general anaesthetic for a termination of pregnancy, while others stated that they liked the awareness of what was happening to them that a local anaesthetic gives. The risk factors associated with general anaesthetic were also cited as reasons for preferring a local option.

I'd take the risk of being depressed after a general

. . . probably a general, I think definitely . . .

Oh, definitely a local.

For me, I wouldn't want to sleep through it.

I would much rather have a general

You can get depressed following a general - I'd definitely have a local.

I mean any surgical procedure, whether it's the dentist or not is invasive, isn't it? Probably people who have problems psychologically with it [the abortion], that's part of it.

Method of termination: Again there were mixed responses from the women in the current study on the issue of preference for surgical termination or self-administered RU-486.[27] Several women stated that the privacy in the use of RU-486 was desirable, while others indicated that they preferred the security of a medical environment.

I think that's a great idea [RU-486]. I mean if there was something that was less nerve racking to go through"

I'd really have to think about it, uh the idea of it would be very appealing. I'd rather take that [RU-486].

Oh definitely, I'd rather take the pill.

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[27]The progesterone blocking pill is scientifically known as mifepristone, but generally known as RU-486. The pill, developed in France, has few side effects and is 96% effective in inducing abortion. As well as its' abortion inducing function, it is recognised as having other medical uses; as a contraceptive, to assist with difficult births and in treatment of Cushings syndrome. RU-486 is not currently available in New Zealand.

No I don't think I would [take RU-486].

The drug thing (?). Yes Oh I think that would be wonderful.

I think I would have rather gone into hospital.

With the abortion at least they can make sure they get everything, you know, and nothing gets left behind.

CHAPTER SEVEN

FINDING MEANING: EXAMINATION OF RESEARCH FINDINGS AND IMPLICATIONS FOR THEORY AND PRACTICE

This chapter examines women's experiences of abortion through the identification of key themes in the narratives which were interpreted in relation to previous research findings. In this chapter, there is also an examination of the ways in which the experience of abortion, as one reproductive option, was perceived by the women in the current study through the exploration of language.

Contraceptive use: The women's reports of contraceptive use, around the time they became pregnant, in the current research are consistent with recent research citing condoms and the oral contraceptive pill as the most commonly used methods of contraception among young New Zealanders (Brander, 1991; McEward et al., 1988). Condoms were the most commonly reported contraceptive used by women in the current study, which is consistent with Brander's (1991) finding.

While previous research has indicated that participants believe contraceptive responsibility should be shared between partners (McEward et al., 1988), the participants in the current research commonly report that their own incompetencies caused contraceptive failure. An interesting observation could be made that none of the women said they considering taking the morning after pill. This could have occurred because, as previous research has noted, women did not believe that pregnancy would happen to them, making the non-use of the morning after pill consistent with non use or irregular use of contraceptives in these women. For other women in the present study who reported taking an oral contraceptive, the morning after pill would not have been a consideration.

Information: It has been reported that people have differing expectations about social support from different groups (Dakof & Taylor, 1990). The type of support most valued from intimates is emotional, whereas doctors are viewed as helpful in

informational roles; desired support from nurses, however mirrors expectations of support from intimates, but to a lesser extent (Dakof & Taylor, 1990). The findings of the current research are consistent with these findings in that reporting of dis-satisfaction with the surgeons involved in the terminations occurred along with reporting of a lack of complete or accurate information, especially with regards to information about pain. This is an interesting trend as it is the nurses who are presenting this information at Lyndhurst and they are viewed without exception, as being completely supportive. They are reported as providing support in the operating theatre and the perceptions of the support are consistent with past research (Dakof & Taylor, 1990).

Who presents information to abortion patients, and what they are presented with and how this information is perceived by women is of concern with regards to the provision of the abortion service. Sceats (1985) found that 10% of women surveyed felt they had not had enough help in making the decision to abort. These women indicated they required more information presenting alternatives to abortion and more information regarding procedure (Sceats, 1985). The women in the present study who reported receiving inaccurate information about procedures and inadequate preparation for pain are similar to Sceats' (1985) finding that women valued being presented with information about techniques, instruments used and how they would feel.

The focus of the responses in the area of information available dwelt very much on the physical, with the emotional aspects conspicuous by their absence. There are two possible reasons for this:

(1) This is a reflection of the primary focus of the service provided at Lyndhurst, and the perception that it is run as a hospital. The women may be responding to their cognitive representation of the environment rather than to the environment as such.

(2) The women did not feel emotionally affected and subsequently did not report information that they did not believe to be personally relevant.

There were indications though, that for some of the women in the present study there were

emotional effects. For example, relationship strain, low levels of distress in the short term.

Decision making process: Partner involvement in the women's decision to terminate is complex, but there are three basic aspects to its occurrence: (a) making the decision for the woman (either through coercion, lack of acknowledgement of and support for a desire to have the baby, absence from the relationship), which would be entirely incongruent with the opportunity for reproductive freedom; (b) supporting the woman as she makes the decision, which would involve acceptance of her choice to terminate and support in raising a child if she chose to; (c) supporting her through the consequences of the decision. Women may want/need varying degrees of support in each area highlighted above, but what was reported by many women in the current study was the first scenario where the decision was made predominantly by partner absence. In other words, the partners absence was the deciding factor.

The statements of women in the current study regarding partner involvement in their decision to terminate their pregnancy are consistent with other studies examining the decision making process in induced termination of pregnancy (Sceats, 1985). The women reported that their partner had not shared an opinion regarding whether to continue the pregnancy or to terminate, and/or that their partner indicated to them that it was their decision. One woman did not disclose to the father, possibly due to her perception that he would be non-supportive. These women, it can be argued, are effected by the non-supportive stance of the father in the decision making process. The perception of support not matching self-identified needs, is apparent in the case of Mandy who indicated that if her partner had told her not to terminate, she would not have gone through with it. Past research has indicated that support from a partner before, during and after a termination is related to a reduction in the likelihood of the woman experiencing negative emotions, such as feelings of loneliness (Robbins & De Lamater, 1985).

The implications for this perceived lack of support from the father are important as past research has shown that women who disclose and perceive others to be less than

completely supportive coped significantly less well than those who either disclosed and perceived complete support or those who did not disclose (Major, et al., 1990). However, in the current study three participants in the current study did not disclose the pregnancy to the father, and their responses to the abortion did not differ from those women who disclosed and had perceptions of poor support.

The potential effects of significant others on the decision to terminate or to continue a pregnancy and the women's subsequent psychological adjustment in the current study are similar to other findings (Bracken, et al., 1978). Women's perception of social support has been shown to be important in the decision making process. Bracken, et al., (1978), found in a sample of women with unexpected pregnancies "those choosing to deliver received significantly more support from parents and partners than those choosing to abort". Participants in the present study reported lack of partner support or involvement as influencing their decision to terminate.

Support from significant others: Parental support has been shown to be less effective than partner support, as was support from other relatives and friends (Robbins and DeLatamer, 1985). The current research findings differ in that support of friends and family members appears to have buffered the effect of lack of partner support with regards to coping following the termination. Lack of disclosure to or support from parents for religious reasons in the current study coincided with poorer levels of post-abortion adjustment. Parental involvement was not relevant to the older participants in the current research, whereas the younger participants placed more emphasis on the perceived support of parents. This tendency is similar to other research findings.

Counselling: The lack of use of counselling services available to the women in the current study could be a function of the fact that the abortion was chosen as a reproductive outcome for an unplanned pregnancy, in a social climate that does not accept the right to abortion. The women frequently report that the abortion was the right decision and therefore experiences of conflict need to be resolved to reduce cognitive dissonance.

The painful experience of abortion: The narratives of the women in the current study have shown that most women found the pain of the operation to be different to what they expected (with the exception of two second terminations, and one no comment). The reporting of pain during the operation was widespread, with the exception of the two terminations in which higher levels of anaesthetic / analgesia were used. It could be that the recollection of the pain is a function of the preparedness for it. For example, if the women were told to expect the pain, would they then report pain to the same extent? There are important implications for the service providers here in terms of informing women accurately of the expected effects of the procedure and the medication used during it. There is also the question of the medical procedure, and whether it can be improved to prevent pain to a greater extent.

Choices within abortion?: There was division in terms of what method women preferred to terminate a pregnancy, with some preferring to control their own termination through the self-administration of RU-486 and others reporting the security of a surgical termination as a more favourable option. This highlights the importance of providing options for the women who chose to terminate a pregnancy. It also reinforces the idea that RU-486 is not the answer to the abortion debate, but is an integral part of providing reproductive freedom for the women involved.

More women preferred the option of general anaesthetic compared to local anaesthetic, and one woman was undecided. Again this highlights the requirement of options for women in order to allow them to control fully their reproductive freedom.

TEXTUAL DECONSTRUCTION

"It is my body, I should choose, and if I don't choose, to whom should I delegate this choice?"
Felicity Green (1987) ***Of Creativity in Women.***

The meaning of choice: Deconstruction involves analysing the operations of differences in texts, and language often provides insights into complex social relations. In

the current study reproductive choice is a critical issue, and it can be argued, the language of "choice" is problematic on two dimensions. On the first instance it can be seen as a socially appropriate euphemism for abortion support, while in the next instance it can be construed as preventing discussion of alternative reproductive "choices" to abortion (Baehr, 1990). The notion of free choice in everyday speech, it is suggested, does not encompass all situations in which reproductive choices are made by women.

Few women make reproductive decisions in situations where their emotional, physical and material circumstances are ideal, and these circumstances are likely to result in a women choosing differently than if circumstances were more favourable (Himmelweit, 1988). For instance, a woman might have a child if she had the financial resources to support it, if there were more affordable day-care options available, if society valued solo parenting, or if she had completed her education or career goals or.

In the experiences of the women in the current study it is rather the circumstances that have dictated the outcome, and their "free choice" is somewhat illusory. The question of wether the term "free choice" adequately describes all circumstances, in a formal sense, that a woman is allowed to make a choice thus remains critical.

An alternative view, argued by Himmelweit (1988), is that in many instances it is circumstances that are the actual determinant of action and that the notion of choice is an illusion that imposes responsibility without freedom. This is a problem for people in a subordinate position in society, and therefore can be seen as especially affecting women. This is apparent in the issue of abortion, where because of societal opinion, it becomes a woman's sole right to choose, placing the burden upon her alone. An example of this can be seen in Sue's rationalization for not disclosing the pregnancy to the father:

> My reaction was, how am I going to manage, you know, bringing up a child on my own...how am I going to work everything out . . . and there was no way at that point, that, that I would have had any support from the father, it wasn't possible, in fact that's the reason I never told him, because he had enough to cope with at that time.

It would appear that the notion of "free choice" is of little benefit to women's reproductive

freedom, as it implies a decision free of constraints that arise in social environments. The concept of freedom to choose better encompasses the idea that while situations are not always ideal and circumstances impact on decisions to a greater or a lesser extent, a woman can make a choice. The concept of reproductive freedom is a useful term as it draws focus to the need to improve factors affecting reproductive choices.

Self determination as a social act: Women's right to control their own body through adequate contraception and access to abortion, is a fundamental liberal argument of individual self-determination; yet the very nature of reproduction requires the involvement of another, as it is an inherently social act. Difficulties occur in claiming individual rights for women to control their bodies are partly the result of the contradiction over the status of women as individuals within a patriarchal discourse, theoretical attempts to move away from the inherently social nature of reproduction, and the centrality of reproduction to the maintenance of the institution of the (heterosexual) family.

This anomaly is evident in the reporting of contraceptive use by women in the current study, where several participants reported feeling not believed, as in the case of Ronnie:

> I don't think they [the doctors] believed me. It's like they thought I'd done it on purpose.

Ellen and Sue accepted total responsibility for using no contraceptives:

> I guess I was a bit, um, well a bit irresponsible
> I ended up having unprotected intercourse, which in hindsight sounds stupid.

Yet Ellen reports, in the course of the narrative, that her previous partner's new girlfriend is pregnant, indicating his irresponsibility. Others accepted individual responsibility for failed contraceptive use, as was the case for Emma:

> We used condoms. I guess I just used them wrong

All of the women acknowledged personal responsibility over contraceptive use through the use of the personal pronoun "I", despite the fact that another person was involved. In

the course of her narrative Sue shows that she believes reproductive choices are controlled by women:

> The whole thing [reproduction/abortion] is your choice anyway, but it's even more your choice if you are taking care of your own body and doing it in your own way.

This perception of personal responsibility is consistent with the perception of some women in the current study that they chose to abort for reasons that they identified, suggesting that it was under their control (See for example pp.48-55).

The inconsistency regarding location of control (internal or external) occurs when explaining the reasons for not continuing the pregnancy. These reasons frequently centred around the lack of partner involvement, consistent with patriarchal ideals of family, so that birth is viewed as a social issue but abortion is viewed as an individual issue.

The two-parent family institution: In the current research women consistently reported that they had made the right decision for themselves at that time. This indicates an acknowledgement that their circumstances were then less than ideal. Many of the women verbalised the patriarchal ideal of the two parent family as part of their decision making process:

> I wasn't all that keen to support a child on my own

> There's no way I could've done it . . . not without a partner, um and already having one I know what it is all about.

> My career was just starting, I couldn't take time off, and anyway, I didn't want it to have no father"

As discussed earlier responsibility for preventing pregnancy is indicated to be an issue of individual concern, with the women accepting this responsibility, and the consequences of pregnancy. The power of the patriarchal discourse is evident also in the women's verbalisations of their capability of solo parenting. The frequent reporting of perceptions of not being able to cope reflect patriarchy on two levels: firstly, limited resources and opportunity that ensure that if mothers are not dependant upon one man

they remain dependant upon the state (male system)[28]; and secondly, the gender socialisation that ensures submissiveness, is reflected in the perception that they are unable to parent effectively without a man to support them.

> I'm not the most paternal person in the world, and I mean, I've got my daughter and I love her to death, but I don't like her very much.
>
> . . . not by myself, not with two. Oh it's hard enough with one. I couldn't cope with two by myself."
>
> I couldn't , um, contemplate having a child on my own, not without support, no. I haven't got the maternal instinct at all.

The narratives of the women also appear to challenge the discourse that presents the maternal instinct as natural and motherhood as a role of nurturing and protecting. Some of the women reported not having a "maternal" instinct, and one women interestingly stated that she was not a "paternal" person.

Definitions of alternate familial situations are taken against the norm of the nuclear family. Opposite definitions are then, a recognition that the "ideal" family constitution has collapsed or not formed in some sense (Angus & Gray, 1995).

The "signifier" of "solo mother" clearly means in male defined terms, that generally constitute normative meanings, to be parenting without the benefit of a male partner. Whereas women's definition of solo motherhood in the current research encompasses the notion of parenting without resources, opportunity, access, support or self-development. This is clearly illustrated in Ronnie's response that if she had a baby she would have to "forget my art, forget my career, forget the rest of my life", and Sue's assertion that solo parenthood was "not all like the Lux soap adds". The women are aware of the discrepancy between the signifier and the signified in the experience of solo parenting. The strength of patriarchal discourses of the family can be seen even in the situation of solo

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[28]Patriarchal constitution of the family has ensured economic dependance in women during times of childbearing when in Western societies they do not work for a period of time. This assurance comes from the lower average wage for women and restricted work opportunities (Bryson, 1993). This imbalance equates to fewer financial resources at the time of birth and fewer opportunities following it.

parenting, where the father most often assumes the role of financially providing, through the state and family support payments, while the mother assumes the caring role.

The impact of religion: Constituted by patriarchy, the mother's position within the institution of the family is designed to legitimate the discourse that privileges the position of men in the family and men's actions. The discourse of religion prevented the mothers from supporting their daughters in the current study illustrating the patriarchal priority of attending to men's interests while the interests of women can be ignored. Religious discourse affected the disclosure of the abortion experience from several women to their family. The fact that these women have born in relative silence their experience of abortion is a direct reflection of the pervasiveness and power of patriarchy (Gerber Fried, 1993). Despite the legalization of abortion and supposed "free choice", patriarchal discourse (as illustrated in Chapter Four) dictates women's reproductive choice both overtly through social policy and covertly through gender socialization processes and the institution of the two parent family.

Enforcing contraceptive choice: The practice of starting women on a course of oral contraceptive pills following a termination is a part of a discourse that implicitly states that women cannot be trusted to use other contraceptive options effectively. This must reinforce the women's perceptions that they were acting irresponsibly and/or were not believed and therefore undermines their autonomy in making reproductive choices. Pressure to take a course of action, such as the pill, is effectively the removal of all rights to choose.

The research expectations addressed: The perceptions of the women interviewed in the current studies show some discrepancy with the findings of recent research, and with the tendencies that were expected to emerge in the current study. The first expectation was that following a termination of pregnancy some women would experience negative disruptions in daily functioning that were not severe or of clinical significance but impacted on their lives. It was also predicted that while a minority of

women would experience severe adverse psychological responses, a majority would find it to be a positive experience. The results of the current study did not reflect this tendency evidenced in the abortion literature (chapter three), possibly due to the smaller sample size and the different method of enquiry. However, what did emerge from the current research was that the pregnancy/abortion experience had an impact on the lives of all of the women, to various extents.

The expectation that younger women would be less satisfied with their abortion experience and have different needs/expectations than older women was not borne out in the current study. What is critical about the current research is that all the women highlighted areas of need that were not being met, particularly in the areas of making the decision, understanding the operation, and preparedness for pain. The levels of satisfaction and information required were not a function of age of participant in the present research and this could be due to two factors; (1) the number of women interviewed and; (2) the nature of the information provided at the abortion clinic.

The expected tendency that women would exhibit a broad pattern of coping behaviour that they engaged in following a termination of pregnancy, that differs from coping behaviour in response to other negative life events was not able to be examined with the number of women participating in the current study.

CHAPTER EIGHT

CONCLUSION: DIRECTIONS IN THE ABORTION ISSUE

Despite the relatively small number of women interviewed in the current study, some important and significant themes were revealed within their narratives of abortion experiences. Women are not a homogeneous group about which unequivocal generalizations can be made, yet despite this, common themes emerged and were identified in the current research.

Unplanned pregnancy and abortion affected the lives of the women involved in the present study, as it does to all women faced with this situation. One of the personally significant effects experienced by participants in the current study was that their relationships frequently ended following confirmation of pregnancy or shortly after termination. They were faced with decisions concerning life goals and whether pregnancy would be compatible with these. Areas in which conflict of interest occurred for these women, when they were faced with an unplanned pregnancy, included educational attainment, career opportunity, economic security and personal fulfilment.

From the women's accounts, it can be assumed that they were adversely affected by negative social attitudes about solo motherhood in New Zealand society, although these negative attitudes were not universally reported. Attitudes of parents and friends towards pregnancy were particularly influential in the decision process. Additionally, the attitudes of family and friends towards abortion prevented disclosure of the experience in some instances. As a function of perceptions of negative attitudes of family, friends and society and therefore non-disclosure of their experience, adequate resources, services and social support were not always perceived as available to the women in the present study.

Inadequate provision of services and resources can perpetuate negative feelings in the women, which in turn reinforces and maintains their disempowerment. Without practical and emotional support the likelihood of negative outcomes following abortion

is increased. This is illustrated in the need for additional information regarding options and abortion procedure in the current research and in past studies (Sceats, 1985).

A striking feature of service provision in Christchurch is the gap between services confirming pregnancy (general practitioner) and those terminating the pregnancy (Lyndhurst Hospital). There appears to be no mandate for counselling/information to be made available to women in the decision making period, covering options and possible outcomes, and no provision of service to ensure that an informed choice is made. This is especially critical as many women during the course of the narrative discussed external factors (stigma of solo parenting, economic dependance, affects of adoption) that impacted significantly on their choice.

Additionally there appears to be little emphasis within the system to endeavour to investigate factors that could have led to a reduction in contraceptive effectiveness. These could be: (a) knowledge of and access to contraception; (b) medical factors and/or incorrect use.

A noticeable feature of the abortion experiences of the women interviewed in the present study is the marked absence of the biological father in the whole process. While several fathers have given varying degrees of support to the women, most often their support is seen was desired yet not expected.

Social policy continues to stigmatise and penalise women who choose not to abort, and who are forced to parent alone, and ensures that the marginal status of women is preserved. Although the nuclear two-parent family is no longer a normative feature of New Zealand family construction, it is still touted as the ideal. Parenting in a situation where there was little or no likelihood of paternal involvement in raising a child was a choice the women in the current study faced with this prospect did not choose. For others, the central aspect in choosing to parent alone was their lack of confidence to parent alone.

Perceptions of motherhood, expressed in the course of their narrative, by the women in the current research were in accordance with traditional conceptualisations of

motherhood as a lifelong vocation for women that necessitates a complete sacrifice of personal interest and ensures economic instability (Griffiths, 1984).

Women in the current study frequently reported feeling blamed for the pregnancy, and the situation they were in. The experience for many of the women in the current study was one of disempowerment. This was reflected in some of the women's narratives where several aspects of their feeling vulnerable can be identified; (1) that the procedural aspects of obtaining an abortion in Christchurch left several women with uncertainty and some with feelings of having little control; (2) the awareness that they were experiencing (physically feeling, hearing, and perceiving) an abortion during the operation along with the physical vulnerability of their position also seems to have been a contributing factor for some women; (3) the attitudes of the operating surgeons that created hierarchical power differentials were an issue for several women.

Many factors have been illustrated in the current study, that have impacted on the women's experiences of abortion. There is a need for further research to be conducted on a broader scale into the effects of current social policies and provision of services on the decision women make when faced with an unplanned pregnancy which also documents long-term outcomes of these decisions. While the present study documents the abortion experiences of a relatively small number of women with diverse backgrounds, and some critical themes were revealed, it is important to acknowledge that, it could be that other women do have access to better resources and support. A further critical factor for future research in the area of abortion services is the nature, context and role of abortion counselling.

It can be seen in the documentation of women's experiences that the outcome of abortion for resolution of an unplanned pregnancy is a part of a complex array of choices, each linked intrinsically to the patriarchal constitution of legal, medical, welfare, and familial discourses that inevitably position women in a subordinate status in society.

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APPENDIX A

WOMEN'S RESPONSES TO THE EXPERIENCE OF ABORTION

INFORMATION FOR THE POTENTIAL PARTICIPANTS

Hi, I'm Nikki Evans. I'm a student at the University of Canterbury, and as part of my studies I'm doing some research to get information from women about their experience of abortion.

I am intending to interview about 100 women, some who have had abortion's a while ago and some who are having them now. I am interested in hearing about your experiences, feelings and what kinds of support you have/had from family and friends.

This research is intended to give me an idea of what it was like to have an abortion and what things were important to you at this time, and how you feel about those issues now.

As I don't have any set questions for you to answer, your involvement will involve an informal interview of about one hour. I just want to hear what you have to say about your experience.

I firmly believe that you should get some benefit from this research process too, I hope that talking about your abortion experience will help you and that what you have to say may be useful in planning services for others that find themselves in a similar situation.

THIS STUDY HAS BEEN APPROVED BY THE CANTERBURY AREA HEALTH BOARD ETHICS COMMITTEE.

APPENDIX B

WOMEN'S RESPONSES TO THE EXPERIENCE OF ABORTION

INFORMATION FOR THE POTENTIAL PARTICIPANTS

Hi, I'm Nikki Evans. I'm a student at the University of Canterbury, and as part of my studies I'm doing some research to get information from women about their experience of abortion.

I am intending to interview about 100 women, some who have had abortion's a while ago and some who are having them now. I am interested in hearing about your experiences, feelings and what kinds of support you have/had from family and friends.

This research is intended to give me an idea of what it was like to have an abortion and what things were important to you at this time, and how you feel about those issues now.

As I don't have any set questions for you to answer, your involvement will involve an informal interview of about one hour. I just want to hear what you have to say about your experience.

I firmly believe that you should get some benefit from this research process too, I hope that talking about your abortion experience will help you and that what you have to say may be useful in planning services for others that find themselves in a similar situation.

Your decision to participate in this research does not affect whether you are accepted for an abortion or not and it does not affect your treatment during the abortion.

THIS STUDY HAS BEEN APPROVED BY THE CANTERBURY AREA HEALTH BOARD ETHICS COMMITTEE.

APPENDIX C

WOMEN'S RESPONSES TO THE EXPERIENCE OF ABORTION

PARTICIPANT CONSENT FORM

I would like you to contribute to a research study on women's experience of abortion. Further information about the study is contained in the attached information sheet. Please read it **BEFORE** you sign this form consenting to participate in the research. If you want to know anything else about the study, please ask. It is really important that you understand what the research involves before you agree to take part.

You don't have to be involved in this study if you don't want to, but if you decide to participate, my commitment to you is that:

(a) no-one else will have access to or hear the tape recording of the interview, and the transcribed interview (the taped interview will be erased at this point) will be verified by you and myself, as the women involved to ensure that the information they are sharing is not mis-interpreted in any way

(b) your name and personal details will be changed so that every thing you say will be completely confidential

(c) you can have the details of any publication of the results or conclusions of the research if you want to

(d) you can be told about the results and conclusions of the research after it is finished if you wish to be.

I am able to give you information about services in Christchurch, should you require any, and can also help with accessing any support services if you need them. If you want to stop being in the study at any time, for any reason just let me know. Please always remember that it is your decision. If you want to know anything else or want to talk about anything following the interview, you can call or write to me:

Nikki Evans
106 Rattray Street
Riccarton
Christchurch
Phone 348 9462

I am probably easiest contacted in the morning or evenings as most afternoons I will be

working or at university.

When you have read these three pages and understand the information on them, if you have decided to be involved in the research please read the following statement and sign your name at the bottom.

The reason for this research has been explained to me, and I have read and understand what my participation in the research involves as it states on the Information sheet and consent form. I agree to take part in the study on women's responses to the experience of abortion.

Participants signature .....date.....

Interviewers signature.....date.....

APPENDIX D

INTERVIEW: SEMI-STRUCTURED THEMES

STUDY 1 & 2.

DEMOGRAPHIC DETAILS

age

ethnicity

previous parity

previous termination(s)

contraceptive use/ type

educational and/or career development/ plans

relationship issues - single, divorced, separated, married, de facto

PERSONAL ISSUES

social support - partner, family, friends

feelings/ experiences; before, during and after termination

feminism

decision making

MEDICAL ISSUES

pain

procedure - expectations, information, support, education

local vs general anaesthetic

surgical termination vs self administered (RU486)

SERVICE ISSUES

counselling - prior to termination

certified consultants - experiences with

information - availability, appropriateness, accuracy

accessibility - support

APPENDIX E

REFLEXIVE METHODOLOGY

Completing the thesis *Beyond abortion: Personal narratives of coping, support and experiences of abortion services,* has been a learning curve for me - at times one with a steep gradient. On reflection I did not anticipate, and could not foresee the struggle that researching this area of women's health would entail. I recently read a report by the Society for Research on Women in New Zealand (1980) examining the abortion experience of a group of women and was astounded that in a decade and a half the restrictions on and difficulties posed in undertaking research in this area, have not abated.

The context of the current abortion legislation became a factor in this project as it became essential to understand the history of the service in order to interpret contemporary provisions: and also the reluctance for this area to be researched.

It became clear to me that the abortion law was not a woman-centred legislation at all. The 1977 abortion law meant that only obstetricians and gynaecologists had operating rights, and at Christchurch Women's Hospital at least, these men were almost all opposed to abortion (Wilkinson & Wilkinson, 1978). This resulted in unsatisfactory practice and poor standards of care for women in Christchurch that included the following (Wilkinson & Wilkinson, 1978).:

- Abortion method was at the discretion and preference of individual surgeons.
- Women routinely and unnecessarily had their vaginas packed after the operation.
- Women were required to strip naked and be examined by doctors (often medical students) and so were treated as bodies only.
- A Depo Provera injection was given (before it was approved in America) in place of contraceptive counselling.
- There was a lack of time for adequate counselling regarding the abortion decision and contraceptive use.
- Most hospital staff members were members of the anti-abortion lobby.
- Decisions of approval for termination were inconsistent

Interestingly, I found the literature concerning women's experience of abortion changed

in focus depending upon the economic climate, but retained the centrality of the issue of women's rights and access to abortion.

It was highlighted by Nicol (1987) that "as far as the main centres were concerned, clinics were by far the most cost effective, safe and efficient way to offer an abortion service". The separate premises for carrying out abortions may have resulted in a better quality service, it also maintained confidentiality in one sense, yet made the service more visible and therefore the women and the staff more vulnerable to targeting from the anti-abortion lobby. It was also highlighted that some general practitioners were refusing to refer women for terminations (Nicol, 1987). Nicol (1987) observed that although the Contraception, Sterilization and Abortion Act (1977) stipulates that counselling should be available, but not that it should be provided. The lack of access to abortion services for geographical reasons is also highlighted.

More recent comment on the provision of abortion services has focused on provider issues. A critical factor in the current economic climate of contracting of services is that the cheapest option is not always best for the women recipients of the service. The dominance of the medical model poses difficulties as the abortion experience does not occur in a vacuum (Federation of Women's Health Councils, 1992). The opting for lower cost procedures could see a reduction in the quality of the service. Market forces may result in women being quickly processed quickly through the service at the expense of adequate support.

I entered into the abortion arena to seek approval from the Canterbury Area Health Board Ethics Committee to conduct research involving women who were recipients of one of their services. This approval took from the 31 July 1992 until the 14 May 1993 to obtain. The research was to be conducted via Family Planning Association, Christchurch, as the Clinical Director of Lyndhurst Hospital declined to support the project. Approval for the study to be undertaken was declined late 1992 and it was conveyed to me that "further such studies be discussed with your supervisor" (Perrott, 1992). The application for

approval was re-submitted early in 1993, with the full support of my supervisors as well as the Manager of Medical Services at Family Planning Association. Several points were raised regarding the research design, specifically relating to the qualitative approach taken. I addressed these points in a written report to the committee, and in attending a meeting with the committee. Written support of the research design and assurance from only one supervisor, Mr N. Blampied was sought. The following section is taken from my copy of this letter:

> The scientific validity of the study is the principal reason for referring the study to you as supervisor. The Committee is asking if you would approve the scientific validity as presented. In coming to this point the Committee acknowledges that taped interviews by comparison of the responses may produce a structure of commentary around which the thesis will be developed. There was some unease that such an analysis could be subject to a preferred interpretation (bias is too strong a term and does not represent the integrity of the researcher properly) and therefore should be considered objectively through an independent assessment. Hence the request for you as supervisor to comment. This is particularly important because of the nature of the topic being studied and the knowledge that very little research has been carried out in this area. From [Ms Evans] viewpoint this could mean the study might gain some significance when finally published and it is important the basis is properly founded now.

The messages underpinning these comments are clear, but the most critical for me were the enquiring of the possibility for Mr. Blampied to check all interviews (as he was presumably less biased than myself), the question of whether I was able to judge if a women was upset (and needed to be referred for counselling) and the statement of one of the male members that he would refrain from commenting on what he thought of the method in the proposed study.

Both Mr N. Blampied and Dr N. Jaber responded to the written request. In May 1993 I was advised that "the Ethics Committee has approved the above study in terms of the arrangements reached with the Social Work Department at Christchurch Women's Hospital and your supervisors" (Perrott, 1993). After speaking with a social worker at Christchurch Women's Hospital about the history of abortion services in Christchurch and the nature of the interviews in the current study, I conducted two 'trial run' interviews with personal friends who had experienced abortion. These interviews assisted me greatly

in preparing for the research interviews. I had some feedback on the interview process and the opportunity to check the tape recording was audible.

I was concurrently disappointed and amazed at the response to my research project by women. I felt disappointed that more women were not asked to participate in the research by medical staff at Family Planning, and astounded at the number of women in the community that offered to be involved in the research; many of whom I barely knew. It is an interesting point to observe, that in the original proposal participants were to be via Family Planning and through personal contacts, but this was taken out on the recommendation of the Ethics Committee for reasons of bias. However, due to the mediation of the medical staff in asking women to participate in the research the sample was smaller and less representative than it would have been should the original design have been retained.

The interviews were conducted with thirteen women, and reflected the narrative style of the participant rather than that of the researcher. I was conscious as the number of interviews progressed that as themes emerged between interviews I became more attuned to them and tended to seek clarification in subsequent interviews that I did not have in the initial interviews. I began to re-frame my understanding of the abortion experience in terms of what I heard rather than what I had expected to find. Unfortunately, sometimes, the women spoke softly and their words were unable to be determined. I did not take additional notes as I felt it would be too disruptive to the interview dynamics, and prevent me from focusing on the women's telling of their narrative. I still do not believe that these would have contributed to the instances described.

The contribution of experience, observations and knowledge by the researcher during the course of the interview was a problematic issue for me. The advantages and limitations of this goal have been debated within feminism, and the one perspective that has emerged is that judgement of the merits must be individually and situationally based

(Reinharz, 1992). In one interview the woman found the experience of researcher self-disclosure a positive factor and indicated it as such. For several other interviews, comment by the researcher appeared to create a hierarchical relationship based on the power of knowledge.

I became aware as the conclusion of the current research project grew near that there was in a sense the privileging of some voices over others in the representations of narrative content. Those women whose style it was to be more verbose presented more experiences in the course of the interview due to the sheer volume of their narrative.

In reflection I believe that the knowledge and learning that I have attained from this project go beyond what is written in this document.